OBAMACARE IMPLEMENTATION PROBLEMS: MORE THAN JUST A BROKEN WEB SITE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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OBAMACARE IMPLEMENTATION PROBLEMS: MORE THAN JUST A BROKEN WEB SITE

THURSDAY, NOVEMBER 14, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:02 a.m., in room 2322 of the Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Shimkus, Murphy, Blackburn, Gingrey, McMorris Rodgers, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Barton, Upton (ex officio), Pallone, Dingell, Capps, Schakowsky, Matheson, Green, Butterfield, Barrow, Castor, Sarbanes, and Waxman (ex officio).

Also present: Representative Terry.

Staff present: Clay Alspach, Chief Counsel, Health; Matt Bravo, Professional Staff Member; Noelle Clemente, Press Secretary; Paul Edattel, Professional Staff Member, Health; Brad Grantz, Policy Coordinator, Oversight and Investigations; Sydne Harwick, Legislative Clerk; Sean Hayes, Counsel, Oversight and Investigations; Nick Magallanes, Policy Coordinator, Commerce, Manufacturing, and Trade; Katie Novaria, Professional Staff Member, Health; Monica Popp, Professional Staff Member, Health; Andrew Powaleny, Deputy Press Secretary; Chris Sarley, Policy Coordinator, Environment and the Economy; Heidi Stirrup, Health Policy Coordinator; Ziky Ababiya, Democratic Staff Assistant; Phil Barnett, Democratic Staff Director; Amy Hall, Democratic Senior Professional Staff Member; Elizabeth Letter, Democratic Assistant Press Secretary; Karen Lightfoot, Democratic Communications Director and Senior Policy Advisor; Karen Nelson, Democratic Deputy Committee Staff Director for Health; and Matt Siegler, Democratic Counsel.

Mr. PITTS. The subcommittee will come to order.

Before giving my opening statement, for planning purposes we have asked the Secretary to confirm her appearance before the subcommittee in the first week of December. As you will remember, the Secretary assured the committee that she would work with us to find a date in early December to provide an update on the implementation, and we look forward to hearing an update from Secretary Sebelius directly in a few weeks.

Also I would like to seek unanimous consent that Congressman Lee Terry can sit with us and take part in today's hearing.

Without objection, so ordered.

The Chair will now recognize himself for an opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Since the disastrous rollout of healthcare.gov on October 1, Americans have learned even more about the Affordable Care Act.

They have learned that if you like your plan, there is a good chance you have or will lose it. Premiums and deductibles are going up, not down, as a result of the Affordable Care Act. Millions have already received cancellation notices for their current insurance policies, and many more will receive similar letters before the end of the year.

The administration keeps telling these people that they will get better, more comprehensive care in an exchange plan. What they don't point out is that premiums in the individual market are going up approximately 40 percent nationwide. Numerous people have contacted my office to share their premiums and deductibles have gone up, some even more than doubling.

Americans have also learned that if you like your doctor, you may not be able to continue seeing him or her. In an effort to keep premiums down in the fact of the law's countless mandates, many exchange plans have narrowed the number of in-network providers, so your doctor or hospital may no longer participate in your insurance plan. Analyses show that more than half of hospitals have still not signed any exchange contracts.

Americans are now learning that when the healthcare.gov Web site does work, the personal information they enter may not be secure. A September 3 internal CMS memo even said that, "The threat and risk potential to the system is limitless."

It is clear that rather than give Americans the peace of mind that comes with good healthcare coverage, the law is making life worse for Americans across the country.

And finally, of the people who were able to successfully use healthcare.gov, many of them ended up enrolling in Medicaid. The program already has serious access problems as many providers refuse to take Medicaid patients. Studies show that the care Medicaid patients receive is often substandard. An influx of newly-eligible patients will further strain the system.

The Affordable Care Act's problems are not limited to a Web site. This law was sold to the American people with false promises, and real people are being hurt. Despite the clear evidence, many supporters of the law still condescendingly assert that Americans are too informed to realize the benefits of the Affordable Care Act. Perhaps it is time for the supporters of the law to look at the front page of any newspaper and face reality. This law is hurting, not helping, Americans.

While it may have been convenient to tell Americans that they can keep their healthcare plan under the Affordable Care Act, it is time for my colleagues to put away that broken promise once and for all. Our constituents deserve better.

Tomorrow the House will have a chance to partially remedy one of the false promises of the Affordable Care Act by voting on H.R.

3350, the Keep Your Health Plan Act of 2013, and I hope all of my colleagues will support this commonsense bill.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

Since the disastrous rollout of healthcare.gov on October 1, Americans have learned even more about the Affordable Care Act.

They have learned that if you like your plan, there is a good chance you have or will lose it. Premiums and deductibles are going up, not down, as a result of Obamacare.

Millions have already received cancellation notices for their current insurance policies, and many more will receive similar letters before the end of this year.

The administration keeps telling these people that they will get better, more comprehensive care in an Exchange plan. What they don't point out is that premiums in the individual market are going up approximately 40% nationwide. Numerous people have contacted my office to share that their premiums and deductibles have gone up, some even more than doubling.

Americans have also learned that if you like your doctor, you may not be able to continue seeing him or her. In an effort to keep premiums down in the face of the law's countless mandates, many Exchange plans have narrowed the number of in-network providers, so your doctor or hospital may no longer participate in your insurance plan. Analyses show that more than half of hospitals have still not signed any Exchange contracts.

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It is clear that rather than give Americans the peace of mind that comes with good health coverage, the law is making life worse for Americans across the country.

Finally, of the people who were able to successfully use healthcare.gov, many ofthem ended up enrolling in Medicaid. The program already has serious access problems, as many providers refuse to take Medicaid patients. Studies show that the care Medicaid patients receive is often substandard. An influx of newly eligible patients will further strain the system.

Obamacare's problems are not limited to a Web site. This law was sold to the American people with false promises, and real people are being hurt.

Despite the clear evidence, many supporters of the law still condescendingly assert that Americans are too uninformed to realize the benefits of the Affordable Care Act. Perhaps it is time for supporters of the law to look at the front page of any newspaper and face reality: this law is hurting, not helping Americans.

While it may have been convenient to tell Americans that they can keep their health care plan under the Affordable Care Act, it is time for my Democrat colleagues to put away that broken promise once and for all. Our constituents deserve better.

Tomorrow, the House will have a chance to partially remedy one of the false promises of Obamacare by voting on H.R. 3350, the Keep Your Health Plan Act of 2013. And I hope all of my colleagues will support this commonsense bill.

Mr. PITTS. I would like to welcome all of our witnesses here today. I look forward to their testimony and yield the balance of my time to Dr. Burgess.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chairman for yielding.

At 3 ½ years later it is pretty obvious this thing was never ready for prime time, was not supposed to get signed into law. It was signed actually by an accident because of the failure of the Democratic House and Senate at that time to come together in a conference committee and count the problems.

We are now left with the debris of this failed promise. My understanding is the President is going to talk to the country in a little

over an hour's time. Perhaps he will have some new light to shed on things.

In the meantime, it is the work of our subcommittee to continue to try to get answers to the American people and to provide them with the relief that they have been so anxiously petitioning our offices in the last several weeks.

We are all worried about the technical problems. I don't doubt at some point technical problems will get solved. I have got great doubts about what the glitches are, who has been appointed, but nevertheless, at some point the technical problems get solved, and then you start the access problems. They start January 1. You are going to have people showing up in doctors' offices and hospitals all over the country in January. They will produce a little card saying they are covered by an insurance company. They will perhaps have made their first payment, but when the bill is submitted, the insurance company may well say I have never heard of this person because the electronic information was not transferred. Would it surprise anyone that that, in fact, could occur given the experience that we have all had for the last 6 weeks with healthcare.gov?

The strain that this will put on the provider community is enormous. The failure of Health and Human Services and the White House to heed the internal warnings about their lack of readiness for the Web site demonstrates that the Obama administration has failed in overall project management and leadership.

The fact is on this subcommittee I have asked the questions that the President said he should have asked before this thing came out. Again, it is the job of our subcommittee to provide answers to those questions and fortunately, tomorrow on the floor of the House we will be able to offer a solution as well.

I yield back to the chairman.

Mr. PITTS. The Chair thanks the gentleman.

I know recognize the ranking member, Mr. Pallone, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman. As usual, I hear all these statements from the other side of the aisle which are just incredibly wrong and inaccurate and unfair.

Let me start out by saying Obamacare, and I won't call it that, the Affordable Care Act is not an accident. It was purposely signed into law because Democrats, unfortunately not Republicans, believe that they could make a difference in improving the healthcare system for Americans. And the fact of the matter is it is not hurting. It is helping.

For the sake of the record, I reiterate that the law is allowing millions of uninsured and underinsured Americans to gain access to comprehensive healthcare coverage. It applies critical consumer protections to new and existing health plans under the law so that no longer can insurers deny someone coverage just because they have cancer, for example, and the fact of the matter is with its passage we are ensuring that healthcare is a right, not a privilege, and

that almost every American, other than, I guess, the undocumented, will have health insurance.

The thing that really bothers me is that I never hear anything from the other side of the aisle talking about what the alternative is. I don't hear anything about what they are going to put in place to make people who are insured or people who are underinsured able to have benefits. The statement by the chairman about the Medicaid situation is incredible to me, and I respect you a lot, Mr. Chairman, but, look: The reason why Medicaid is not being expanded in a lot of States is because Republican governors have refused to expand it, but they are not coming up with an alternative. They are not saying, OK, now you can't get Medicaid, and therefore, you can get something else. They have no alternative, even though they would get 100 percent funding to expand it.

And the same thing, I hear the chairman say, well, you are going to have Medicaid coverage, which is a good thing because you have no coverage right now, but you may not be able to find a doctor, or the doctor may not take the reimbursement rate. Well, then the purpose of this committee is to fix that. Fix the Medicaid problem. Provide more funding. You know, fix the reimbursement rate.

Now, I know we have made some progress with that on the Medicare front with Dr. Burgess, and I certainly don't want to take away from that with the SGR, but what about Medicaid?

So I don't believe that there is any interest on the part of the Republicans to fix any of the problems that are occurring with the rollout of the Affordable Care Act. They simply want to demonize the President and his policies. They will go to any length to do so, and at the top of the list are these efforts to sabotage Obamacare and force its failure. And the best example of that is what they are proposing tomorrow with the chairman of our committee, Mr. Upton.

I called a previous hearing of the committee a monkey court. I will call this the monkey wrench. The Upton bill is the monkey wrench that they are trying to throw in to basically destroy Obamacare, because what it essentially does, it says that insurance companies that have these lousy policies, skeletal policies, they can continue to sell them. Actually, they can continue to sell them now, but they want to expand that opportunity and allow them to sell policies that are skeletal, that only cover catastrophic, that don't cover hospital care, for example, and in the Upton bill, the monkey wrench, they are even proposing that not only the people that have those policies but new people can buy those policies.

And so what does that do? It means that the healthier people, it means that the younger people can buy these skeletal catastrophic policies that they may not even be aware of what is covered, and then the insurance pool is broken, and prices go up for everyone else. And the problem right now unfortunately is that we have this Web site that doesn't work, and a lot of people, when their policies are canceled by the insurance companies, not by the Affordable Care Act, don't realize that they have a place to go where they can find a better policy for an affordable price—because the Web site is not working.

So, again, we have to fix the Web site. I appreciate the fact that Dr. Burgess said that it will be fixed. He has got the confidence

that it will be fixed, but, again, the problem here is that, again, this subcommittee is really not having an oversight or implementation hearing. I think it is quite clear from what has already been said by my Republican colleagues that they just think Obamacare or the Affordable Care Act should be repealed, and you know, we cannot go down that road because it is providing help for so many Americans, and the Republicans have no alternative. They never have, and that is my biggest criticism of all of you on the other side. I never hear the alternative.

Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the chairman of the full committee, Mr. Upton, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Well, thank you, Mr. Chairman.

You know, since 2009, this committee and the Congress has vigorously debated the consequences of the President's healthcare law and what it would mean for patients and families across the country. These past 45 days have provided a disturbing glimpse of what reality looks like under the President's healthcare bill. Millions of Americans are losing their private, affordable coverage, premiums are skyrocketing, Medicaid is enduring an untenable expansion to burden it from its core mission, and a Web site continues to frustrate Americans online and will continue to do so probably long after the November 30 date that the Secretary told us just 2 weeks ago would work.

The results correctly described in recent news reports have been nothing short of disastrous. Enrollment figures finally released just yesterday underscore some of the law's most significant issues as well as fundamental broken promises. Fifty times as many folks are receiving cancellation notices than are even selecting a plan on healthcare.gov, and nearly 80 percent of this first figures are Medicaid dependents, an ominous forecast of what is in store for the program originally designed to assist those Americans most in need of the helping hand. In other words, the most vulnerable.

And for those with health plans, premiums are skyrocketing across the country. In my State, Michigan, residents face an estimated almost 70 percent average increase in the individual market under the President's healthcare law. That isn't healthcare reform. That is not what the American people were promised.

While the broken Web site continues to define the first weeks and months of open enrollment, the law itself has been constructed on a series of broken promises. Regardless of whether or when the computer glitches are fixed, the law's problems run even deeper. The broken promises of, if you like your plan, you can keep it, period, and the premiums would go down an average of $2,500 are causing unneeded worry, anxiety, and hardship for households across the country. Cancellations today, sticker shock tomorrow.

Sadly, the news probably is only going to get worse. Cancellations stem far beyond 5 percent of Americans that the President claims are affected by his broken promise. Many workers with employer-sponsored insurance have learned or will soon learn that the

President's healthcare law is going to take away their coverage as well.

So beyond these broken promises the law's Medicaid Expansion threatens our commitment to the Nation's most vulnerable, potentially adding 26 million Americans to its roster, further straining the important safety net program.

So the first days of the healthcare law have caused many Americans to lose faith in their government, revealing the ugly truth of what Washington-driven, big-government healthcare can look like.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Since 2009, this committee and the Congress has vigorously debated the consequences of the president's health care law and what it would mean for patients and families across the country. These past 45 days have provided a disturbing glimpse of what reality looks like under the Affordable Care Act—millions of Americans are losing their private, affordable coverage, premiums are skyrocketing, Medicaid is enduring an untenable expansion diverting it from its core mission, and a Web site continues to frustrate Americans online, and will continue to do so long after November 30. The results, correctly described in recent news reports, have been "nothing short of disastrous."

Enrollment figures finally released just yesterday underscore some of the law's most significant issues as well as a fundamental broken promise. Fifty times as many folks are receiving cancellation notices than are even selecting a plan on HealthCare.gov. And nearly 80 percent of these first figures are Medicaid-dependents, an ominous forecast of what's in store for the program originally designed to assist those Americans most in need of a helping hand.

And for those with health plans, premiums are skyrocketing across the country. In my home State of Michigan, residents face an estimated 69% average increase in the individual market under the Affordable Care Act.

This is not health care reform. This is not what the American people were promised. While the broken Web site continues to define the first weeks and months of open enrollment, the law itself has been constructed on a series of broken promises.

Regardless of whether or when the computer glitches are fixed, the law's problems run much deeper. The broken promises of "if you like your plan, you can keep it, period," and that premiums would go down an average of $2,500 are causing unneeded worry, anxiety, and hardship for households across the country. Cancellations today, sticker shock tomorrow.

Sadly, the news is only going to get worse. Cancellations stem far beyond the 5 percent of Americans that the president claims are affected by his broken promise. Many workers with employer-sponsored insurance have learned or will soon learn the ACA is going to take away their coverage as well.

Beyond these broken promises, the law's Medicaid expansion threatens our commitment to the Nation's most vulnerable, potentially adding 26 million Americans to its rosters, further straining the important safety net program

The first days of the health law have caused many Americans to lose faith in their government, revealing the ugly truth of what Washington-driven, big government health care can look like.

Mr. UPTON. I yield the balance of my time to Mr. Terry.

OPENING STATEMENT OF HON. LEE TERRY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Mr. TERRY. Thank you, Chairman Upton, and I appreciate you yielding, and this is an issue of trust, and basically if we can't trust the administration to create and run a Web site, how can we trust them with the big issues of running our healthcare? We have heard you can have your insurance, keep your insurance if you want it. We have heard that this will be the most open and transparent administration, but those have been violated. Just a week or two ago when Secretary Sebelius responded to my question about informa-

tion about who was entering or how many had entered, we were told she could not give us that number because the numbers were unreliable. Well, they had the numbers. It was just that they didn't have their story straight.

Now, she did release the numbers yesterday. We learned that 338 Nebraskans signed up. We learned that there were a total of 106,000 that signed up, most of them for Medicare expansion. We are being told it was 700,000, including a press conference or a press call right after the hearing last week.

So my bill restores that trust. We have insurance commissioners in every State to which the administration has not communicated with. So this bill is simple. It provides information to the decision makers, the insurance commissioners and governors' office of each State. It requires a State-by-State breakdown of that data. This is not a partisan bill. It will keep insurance commissioners at the State level and the American people involved in this Act, and they will be able to sort through the details, and that will help regain the trust.

And I yield back.

[The information follows:]

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113TH CONGRESS
1ST SESSION

H. R. 3362

To amend the Patient Protection and Affordable Care Act to require transparency in the operation of American Health Benefit Exchanges.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 29, 2013

Mr. TERRY (for himself and Mr. CASSIDY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Patient Protection and Affordable Care Act to require transparency in the operation of American Health Benefit Exchanges.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Exchange Information Disclosure Act".

SEC. 2. WEEKLY REPORTS ON HEALTH BENEFIT EXCHANGES.

Section 1311(c)(5) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(5)) is amended—

(1) in subparagraph (A), by striking "and" at the end;

(2) in subparagraph (B), by striking the period and inserting a semicolon; and

(3) by inserting after subparagraph (B) the following:

"(C) not later than the first Monday after the date of enactment of this subparagraph, and each Monday thereafter through March 31, 2015 (or the next business day when Monday occurs on a Federal holiday), in coordination with the with Secretary of the Treasury and the Secretary of Labor, submit to Congress and make available to State governors, State insurance commissioners, and the public, a report concerning consumer interactions with the Internet website maintained by the Federal Government for health insurance coverage (healthcare.gov or any subsequent Internet site (or sites) that is established in whole or in part by the Federal Government to facilitate enrollment in qualified health plans, the receipt of

advance premium tax credits or cost sharing reduction assistance, or comparisons of available qualified health plans) and any efforts undertaken to remedy problems that impact taxpayers and consumers, such report to include—

"(i) a State-by-State break down of—

"(I) the number of unique website visits;

"(II) the number of web chat logins;

"(III) the number of individuals who create an account;

"(IV) the number of individuals who enrolled in a qualified health plan or Medicaid;

"(V) the number of enrollees in each zip code; and

"(VI) the level of coverage obtained;

"(ii) a detailed description of the problems identified with website functionality, the actions that have been taken to resolve those problems, the identity of the contractors that are involved in such actions, the cost of such actions, how

such actions are being paid for, and the names of the Federal officials responsible for overseeing the process; and

"(iii) a description of the separate problems with the website, including problems relating to—

"(I) logging into the website;

"(II) enrolling in coverage;

"(III) transferring to the State Medicaid programs;

"(IV) the calculation of advance premium tax credits or cost sharing reductions;

"(V) eligibility for qualified health plans, advance premium tax credits, cost sharing reductions, Medicaid, or the Children's Health Insurance Program;

"(VI) income or identity verification;

"(VII) the transfer of information to health insurance issuers; and

"(VIII) consumer privacy and data security; and

"(D) not later than the first Monday after the date of enactment of this Act, and each Monday thereafter through March 31, 2015 (or the next business day when Monday occurs on a Federal holiday), in coordination with the with Secretary of the Treasury and the Secretary of Labor, submit to Congress and make available to State governors, State insurance commissioners, and the public, a report concerning the Federally operated customer service call center, including the number of calls received by the call center, the Internet website or enrollment problems identified by users, how many calls are referred to the Centers for Consumer Information and Insurance Oversight, how many calls are referred to State insurance commissioners, and how many callers enrolled in a qualified health plan through the call center.".

SEC. 3. DISCLOSURE OF NAVIGATOR AND CERTIFIED APPLICATION COUNSELOR GRANTEES.

Section 1311(i) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(i)) is amended by adding at the end the following:

"(7) PUBLIC AVAILABILITY OF LIST OF NAVIGATORS.—Not later than 5 days after the date of enactment of the Exchange Information Disclosure Act, the Secretary shall make available to Congress, State attorneys general, State insurance commissioners, and the public a list of all navigators and certified application counselors that have been trained and certified by Exchanges, including contact information for all navigator entities and their partner organizations, including subcontractors. Such list shall be updated by the Secretary on a weekly basis through March 31, 2015.".

SEC. 4. DISCLOSURE OF CERTIFIED AGENTS AND BROKERS.

Section 1312(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(e)) is amended by adding at the end the following flush sentence: "Not later that 5 days after the date of the enactment of the Exchange Information Disclosure Act, the Secretary shall make available on the Internet website maintained by the Federal Government for health insurance coverage (healthcare.gov or any subsequent Internet site (or sites) that is established in whole or in part by the Federal Government to facilitate enrollment in qualified health plans, the receipt of tax credits or cost sharing reduction assistance, or comparisons of available qualified health plans)

a list of all agents and brokers who have been trained and certified by the Federal Exchange, including their name, business address (if available), and phone number. Such list shall be updated on a weekly basis through March 31, 2015.".

○

Mr. PITTS. The Chair thanks the gentleman.

I now recognize the ranking member of the full committee, Mr. Waxman, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman.

The Affordable Care Act has always aroused strong passions among opponents and defenders of the law, and as a supporter of the law, I see it as part of one of my core missions in public life; to help every American get access to quality healthcare regardless of his or her income or background. It is about fairness, justice, and compassion.

The Republican obsession with thwarting the law has always puzzled me because the law is premised on three fundamentally conservative notions; lowering healthcare costs, individual responsibility to have coverage, and the private health insurance market. Making sure that every American has health coverage was once a favorite policy of the Conservative Heritage Foundation. It was meant to insure that people take responsibility for their own health costs rather than forcing them onto everybody else.

Because of the Affordable Care Act millions of Americans who would have gone uninsured will have coverage. Just yesterday we learned that 1.5 million people have already applied for coverage, a faster pace than Massachusetts when they enacted a very similar law. Even with all the technical problems we have had, people are getting access to insurance. In my State nearly 400,000 people have begun applications in just the first month.

These are significant signs of progress. They show we are on our way to dramatically expanding health insurance coverage in this Nation.

The law is also slowing the growth in healthcare costs. All healthcare costs. Due to the law's sensible reforms, hospital readmissions are down 10 percent in the Medicare Program since 2011. Hundreds of providers are now joining Affordable Care organizations, putting us on the path to pay for the quality of healthcare, not just the quantity of care, and we have seen health costs grow at their slowest rate in 50 years.

Reform is working. However, it is obvious to all that there are great challenges when a program like this gets going. Too many Americans have gotten worrisome letters from their insurers. These letters can give the misleading impression that people will be left without any insurance coverage starting January 1, and the Federal Web site is not working well. So many people don't yet know what options they have.

But here are the facts. Americans who have insurance through their employers or Medicare or Medicaid will keep their current coverage, and those who buy new plans on the exchange will often get better plans at a lower cost. The 240 million people with employer coverage or coverage through a public program will not see significant changes next year because of the ACA. Within the much-smaller individual insurance market, nearly 5 million people will be eligible for a tax credit worth an average of $5,000, which

will lower their out-of-pocket costs. Over one million more people will be eligible for Medicaid, which means additional savings.

Millions more will finally get a good deal on quality coverage. No one can be denied coverage because of a pre-existing condition. No one can see higher rates because they have been sick. No one can see their rates go up if they do get sick. No one will run up against an annual coverage limit or realize too late that their plan doesn't cover key benefits. That is the status quo the Republicans want to continue. These insurers' abuses.

Tomorrow the House will vote on a bill that would jeopardize all of these reforms. It would send us back to a world where insurers can offer plans that provide no real protections or exclude people based on pre-existing conditions. Under the Republican bill insurers could cherry pick the best risks and destabilize the insurance market for everyone else.

I know that a transition to a more fair and stable marketplace may not always be easy, but we cannot go back to the discriminatory, inefficient market we have had before.

I look forward to hearing from Professor Corlette and Reverend Dixon Hill about the progress we have made and why we cannot turn back now.

Thank you, Mr. Chairman.

Mr. PITTS. The chairman thanks the gentleman.

On our panel today we have five witnesses, and I will introduce them at this time.

First, the Honorable Mike Astrue, former Commissioner, Social Security Administration, Mr. Avik Roy, Senior Fellow, Manhattan Institute for Policy Research, Ms. Sabrina Corlette, Research Professor, Health Policy Institute, Georgetown University, Reverend Marilyn Dixon Hill, Registered Nurse and Clergyperson, Camden Bible Tabernacle, and I would like to yield 30 seconds to Congresswoman McMorris Rodgers to introduce our last witness.

Mrs. MCMORRIS RODGERS. Thank you, Mr. Chairman.

It is my great pleasure to introduce one of our witnesses today, Dr. Roger Stark. He is a surgeon from my home State, Washington, and has been seeing firsthand the impact of the implementation of Obamacare as it is crowding out private insurance, both in Washington State and across our country. He is a cornhusker, graduating from the University of Nebraska, College of Medicine, completed post-graduate training at the University of Utah, Virginia Mason Medical Center and the University of Washington. He is a member of Alpha Omega Alpha, a national medical honorary society, and in addition, he has devoted many years to the study of healthcare policy and currently serves as the healthcare policy analyst at the Washington Policy Center, which is an independent, non-profit, non-partisan healthcare think tank located in Washington State.

So I thank Dr. Stark for being here today.

Mr. PITTS. The Chair thanks the gentlelady.

Thank you all for coming. You will have 5 minutes to summarize your testimony. Your written testimony will be entered into the record, and at this point I would like to recognize the Honorable Astrue for his opening statement.

STATEMENTS OF MICHAEL J. ASTRUE, FORMER COMMISSIONER, SOCIAL SECURITY ADMINISTRATION; AVIK ROY, SENIOR FELLOW, MANHATTAN INSTITUTE FOR POLICY RESEARCH; SABRINA CORLETTE, SENIOR RESEARCH FELLOW, CENTER ON HEALTH POLICY REFORMS, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE; MARILYN DIXON HILL, ASSOCIATE PASTOR, CAMDEN BIBLE TABERNACLE; AND ROGER STARK, HEALTH CARE POLICY ANALYST, WASHINGTON POLICY CENTER

STATEMENT OF MICHAEL J. ASTRUE

Mr. ASTRUE. Chairman Pitts, Ranking Member Pallone, members of the subcommittee, thank you for this opportunity to testify today.

I am a former HHS General Counsel and Commissioner of Social Security. In the latter capacity I also served as a Trustee of the Social Security and Medicare Trust Funds. As Commissioner I oversaw the replacement and expansion of most parts of Social Security's highly-rated suite of electronic services. That work included complex projects, including electronic services for filing for retirement, disability, and Medicare.

To reduce the hearings backlog, we built a fully-electronic system so representatives could access status reports directly and conduct video hearings from their own offices. We introduced novel services such as online filing in Spanish and a NIST Level III service for supplying online earning statements. The agency is now rolling out a massive state-of-the-art IT system for the 54 State and territorial disability determination agencies.

During my watch we worked with HHS on several new programs under the Affordable Care Act, most notably the healthcare exchanges. I have seen attempts to blame its so-called glitches on silly explanations ranging from enthusiasm for the exchanges to the policies of Ronald Reagan. The simple truth is that HHS mismanaged the process, failure was not inevitable, it was achieved.

Former Administrator Berwick failed to put in place the basic assignments, goals, and systems of accountability necessary to manage a project of this scope. There was no full-time senior project manager, there were no bi-weekly or monthly team meetings with Berwick, and there were no specifications for most major parts of the system at the point where he left office. HHS made little progress on Berwick's watch.

By the time Marilyn Tavenner became Acting Administrator, it was common knowledge inside the Executive Branch that HHS was compromising quality in order to meet last month's deadline. Decisions started to be made but were made in a disjointed and siloed fashion. Senior executives began to express confidence that support for the Affordable Care Act was so strong that they would be able to fix the problems of the exchanges after the launch.

Lack of transparency during this time period helped to doom the system. The small doses of accountability that come from demonstrating your work to experts, colleagues, and other agencies and advocacy groups did not occur with this project.

It is also important to understand that our statutory watchdog, HHS Inspector General Daniel Levinson, undermined transparency

during this critical period. His auditors, who should have been alerting Congress and the public about the chaos at HHS, did nothing. His sole contribution was a four and a half page analysis on August 2 of this year that can be summarized as, HHS tells us that everything will be fine.

Since that time the Congressional testimony of Levinson's representatives has been smug and unhelpful. I challenge you to read the list of Inspector General audit reports for this year and to identify just one report that you wouldn't trade for a thorough audit of the functionality and security of the exchanges. In short, good government requires a new Inspector General.

If the Inspector General had done his job properly, President Obama and his advisors would know that asking Jeffrey Zients, an able public servant, to fix the exchanges in just 1 month is a recipe for failure. While I believe functionality may improve in the coming months, this frantic effort to make thousands of adjustments does not leave Mr. Zients with enough time to make or test changes, which cannot be done in isolation but which must be tested as a whole. Anyone with experience in building these kinds of systems knows that even minor changes in one part of a system can cause major unexpected problems in seemingly unrelated parts of the system. The so-called IT surge is a mistake that will compound past mistakes. The work should not drive the schedule. The schedule should drive the work.

These past mistakes are even dragging down State exchanges that were working before October 1. In Massachusetts where I live we operated a seamless exchange before the passage of the Affordable Care Act, however, now according to the Boston Herald, once it was linked to the Federal hub, it began requiring that some applicants identified themselves as inmates or mental patients, people with hyphenated names, disproportionately women, are being denied service. Only 549 of the 150,000 people being denied insurance coverage through the Affordable Care Act have registered for a policy, and none of these people in Massachusetts have insurance yet.

A true fix is impossible in 1 month because the shortcuts taken to meet the October 1 deadline abandoned the usual cyber security defenses. Extensive unencrypted data flowing from the so-called, "cloud," through the exchanges makes it a hacker's dream. CNN and others have hired hackers who have easily penetrated the system and obtained sensitive, personal information, including answers to security questions commonly used by banks, brokerages, and medical institutions.

I believe painful breaches of the HHS Systems are just a matter of time, and that a true fix cannot happen quickly or cheaply. Primarily for that reason, Americans will increasingly hesitate to use the exchanges. We should stop demanding shortcuts. Instead, we should insist on greater transparency, greater candor, greater respect for the privacy of Americans, and greater technical competence.

Thank you.

[The prepared statement of Mr. Astrue follows:]

Testimony of Michael Astrue for the House Energy and Commerce Subcommittee on Health

November 14, 2013

Chairman Pitts, Ranking Member Pallone and Members of the Subcommittee, thank you for this opportunity to testify today.

I am a former HHS General Counsel and Commissioner of Social Security. In the latter capacity, I also served as a Trustee of the Social Security and Medicare Trust Funds.

As Commissioner I oversaw the replacement and expansion of most parts of Social Security's highly rated suite of electronic services. That work included complex projects, including electronic services for filing for retirement, disability and Medicare. To reduce the hearings backlog, we built a fully electronic system so representatives could access status reports directly and conduct video hearings from their offices. We introduced novel services, such as online filing in Spanish and a NIST Level III service for supplying online earnings statements. The agency is now rolling out a massive state-of-the-art IT system for the 54 state and territorial disability determination agencies.

During my watch, we worked with HHS on several new programs under the Affordable Care Act, most notably the health care exchanges. I have seen attempts to blame its so-called "glitches" on silly explanations ranging from enthusiasm for the exchanges to the policies of Ronald Reagan. The simple truth is that HHS mismanaged the process; failure was not inevitable—it was achieved.

Former Administrator Berwick failed to put in place the basic assignments, goals and systems of accountability necessary to manage a project of this scope. There was no full-time senior project manager, there were no biweekly or monthly team meetings with Berwick, and there were no specifications for most major parts of the system at the time he left office. HHS made little progress on Berwick's watch.

By the time Marilyn Tavenner became Acting Administrator, it was common knowledge inside the executive branch that HHS was compromising quality in order to meet last month's deadline. Decisions started to be made, but were made in a disjointed and siloed fashion. Senior executives began to express confidence that support for the Affordable Care Act was so strong that they would be able to fix the problems of the exchanges *after* the launch.

Lack of transparency during this time period helped to doom the system. The small doses of accountability that come from demonstrating your work to experts, colleagues in other agencies, and advocacy groups did not occur with this project.

It is important to understand that our statutory watchdog, HHS Inspector General Daniel Levinson, undermined transparency during this critical period. His auditors, who should have been alerting Congress and the public about the chaos at HHS, did nothing. His sole contribution was a four-and-a-half page analysis on August 2 of this year that can be summarized as "HHS tells us everything will be fine."

Since that time, the Congressional testimony of Levinson's representatives has been smug and unhelpful. I challenge you to read the list of Inspector General audit reports for this year and to identify *just one* report that you wouldn't trade for a thorough audit of the functionality and security of the exchanges. In short, good government requires a new Inspector General.

If the Inspector General had done his job properly, President Obama and his advisors would know that asking Jeffrey Zients, an able public servant, to "fix" the exchanges in just one month is a recipe for more failure.

While I believe functionality may improve a bit in the coming weeks, this frantic effort to make thousands of adjustments does not leave Mr. Zients with enough time to make or test changes, which cannot be done in isolation, but which *must* be tested as a whole. Anyone with experience in building these kinds of systems knows that even minor changes in one part of a system can cause major unexpected problems in seemingly unrelated parts of the system. The so-called "IT surge" is a mistake that will compound past mistakes.

These past mistakes are even dragging down state exchanges that were working seamlessly before October 1. In Massachusetts, where I live, we operated a seamless exchange before the passage of the Affordable Care Act. However, according to the *Boston Herald*, once it was linked to the federal hub it began requiring that some applicants identify themselves as inmates or mental patients. People with hyphenated names, disproportionately women, are being denied service. Only 549 of the 150,000 people being denied insurance coverage due to the Affordable Care Act have registered for a policy, and *none* of those people have insurance yet.

A true fix is impossible in one month because the shortcuts taken to meet the October 1 deadline abandoned the usual cybersecurity defenses. Extensive unencrypted data flowing through the so-called "cloud" make the

exchanges a hacker's dream. CNN and others have hired hackers who easily penetrated the system and obtained sensitive personal information, including answers to security questions used by banks, brokerages and medical institutions.

I believe painful breaches of the HHS systems are just a matter of time, and that a true fix cannot happen quickly or cheaply. Primarily for that reason, Americans will increasingly refuse to use the exchanges despite financial penalties and the greater penalty of remaining uninsured.

We should stop demanding shortcuts. Instead, we should insist on greater transparency, greater candor, greater respect for the privacy of Americans, and greater technical competence.

Thank you.

Mr. PITTS. The Chair thanks the gentleman and now recognizes Mr. Roy, 5 minutes for an opening statement.

STATEMENT OF AVIK ROY

Mr. ROY. Chairman Pitts, Ranking Member Pallone, and members of the Health Subcommittee, thanks for inviting me to speak with you today about the Affordable Care Act.

My name is Avik Roy, and I am a Senior Fellow with the Manhattan Institute for Policy Research, in which capacity I conduct research on healthcare and entitlement reform.

I am advocate of market-based universal coverage. I believe that the wealthiest country in the world can and should strive to protect every American from financial ruin due to injury or illness. Furthermore, I believe that well-designed, subsidized insurance marketplaces are among the most attractive vehicles for achieving these goals.

It is for these reasons that I am deeply concerned about the way in which the ACA's insurance exchanges have been designed and implemented. Most of all, I am concerned that the law will drive up the cost of health insurance, especially for people who shop for coverage on their own.

As you know, the ACA makes substantial changes to the individual health insurance market. The law broadly bars insurers from charging different rates to the sick and to the healthy and requires insurers to raise rates on younger individuals in order to partially subsidize coverage for the old. It mandates that insurers cover a broad range of services that individuals might not otherwise choose to purchase. The law taxes premiums, pharmaceuticals, and medical devices in a manner that has a net effect of increasing the cost of insurance.

Earlier this month I and two colleagues at the Manhattan Institute completed the most comprehensive study to date of individual market premiums in 2014, relative to 2013. We examined the five least expensive plans available in the individual market for every county in the United States, averaged their premiums, and adjusted the result to take into account those who, due to pre-existing conditions, could not purchase insurance at those rates. We examined premiums for 27-, 40-, and 64-year-old men and women. We then compared those rates to the comparable ones on the ACA exchanges.

Our analysis found that the average State will see a 41 percent increase in underlying premiums prior to the impact of subsidies. Among the States seeing large increases as North Carolina at 136 percent, Georgia at 92 percent, Michigan, 66 percent, Louisiana, 53 percent, and Kentucky at 47 percent, and Illinois at 43 percent.

Our analysis did find that eight States will see average premiums decrease under the law, including New York, a decline of 40 percent, and New Jersey, a decline of 19 percent.

Of the six categories we studied, 27-year-old men face the steepest increases with an average hike of 77 percent. Forty-year-old women see the mildest increases with an average of 18 percent.

We also studied the impact of the law's premium assistance payments on exchange premiums. Our analysis found that for individuals of average income taxpayer-funded insurance subsidies pri-

marily flow to those nearing retirement. This is because the elderly will still pay more for insurance on average than younger individuals and because the subsidies are designed to fix the percentage of one's income devoted to paying for health insurance premiums. Taking subsidies into account, 64-year-old men will pay on average 19 percent less for insurance under the ACA System, whereas 27-year-old men will pay 41 percent more.

The Manhattan Institute analysis indicates that we are, indeed, likely to see a fair amount of adverse selection on the exchanges. People who consume an above-average amount of healthcare services such as sick or older individuals, have a compelling economic incentive to enroll in the ACA marketplaces. Healthier and younger individuals have less of an incentive, even when one takes the individual mandate into account.

While many in the press are focused on the exchange enrollment figures that HHS released yesterday, what is more important than the number of people who enroll in the exchanges is the composition of the people who enroll in the exchanges. This will give us a sense of whether or not marketplace premiums are likely to further increase in 2015, and 2016, exacerbating the problem of adverse selection.

Our analysis did not directly examine the degree to which exchange-based plans have higher deductibles and narrower provider networks relative to plans available in 2013. There have been, however, many anecdotal reports of people paying higher premiums for plans with higher deductibles and narrower physician networks than the plans they previously enjoyed.

It is not inherently a bad thing for individuals to choose plans with higher deductibles and narrower networks, especially if those choices allow Americans to reduce their monthly premiums. However, in the case of the ACA, many individuals are reporting higher premiums for less attractive health coverage.

It would be one thing if the ACA was forcing Americans off their old health insurance policies and offering them more attractive plans at a lower price, but millions of Americans are likely to see less attractive coverage at a higher price. If they do, then the Affordable Care Act will not live up to its name, and its goal of near-universal coverage will remain unfulfilled.

I look forward to your questions and to being of further assistance to this committee. Thank you.

[The prepared statement of Mr. Roy follows:]

Testimony before the Health Subcommittee of the House Energy and Commerce Committee

November 14, 2013

Obamacare Implementation Problems: More Than Just A Broken Website

Avik Roy
Senior Fellow, Manhattan Institute for Policy Research

Written Statement

Chairman Pitts, Ranking Member Pallone, and members of the Health Subcommittee: thanks for inviting me to speak with you today about the Affordable Care Act.

My name is Avik Roy, and I'm a Senior Fellow at the Manhattan Institute for Policy Research, in which capacity I conduct research on health care and entitlement reform.

I am an advocate of market-based universal coverage. I believe that the wealthiest country in the world can, and should, strive to protect every American from financial ruin due to injury or illness. Furthermore, I believe that well-designed, subsidized insurance marketplaces are among the most attractive vehicles for achieving these goals.

It is for these reasons that I am deeply concerned about the way in which the ACA's insurance exchanges have been designed and implemented. Most of all, I'm concerned that the law will drive up the cost of health insurance, especially for people who shop for coverage on their own.

The ACA transforms the individual market

It is commonly thought that the market for people who shop for health coverage on their own—the so-called "non-group" or "individual" market—is relatively small. The Congressional Budget Office estimates that, in 2013, of the 268 million Americans with

health coverage, approximately 9 percent—25 million—purchased coverage on their own.

But a market does not consist merely of the people who buy a product. It also consists of the people who consider buying a product, and choose not to. In this case, that means the uninsured. The 57 million uninsured are people who have declined to purchase non-group coverage, in many cases because that coverage is too expensive.

As you know, the ACA makes substantial changes to the individual health insurance market. The law broadly bars insurers from charging different rates to the sick and the healthy, and requires insurers to raise rates on younger individuals in order to partially subsidize care for the old. It mandates that insurers cover a broad range of services that individuals might not otherwise choose to purchase. The law taxes premiums, pharmaceuticals, and medical devices in a manner that has the net effect of increasing the cost of insurance.

The Manhattan Institute study: Underlying premiums increase by an average of 41%

Earlier this month, I and two colleagues at the Manhattan Institute completed the most comprehensive study to date of individual-market premiums in 2014 relative to 2013. The analysis can be found here:

http://www.forbes.com/sites/theapothecary/2013/11/04/49-state-analysis-obamacare-to-increase-individual-market-premiums-by-avg-of-41-subsidies-flow-to-elderly/

We examined the five least-expensive plans available in the individual market for every county in the United States, averaged their premiums, and adjusted the result to take into account those who, due to pre-existing conditions, could not purchase insurance at those rates. We examined premiums for 27-, 40-, and 64-year old men and women.

We then compared those rates to the comparable ones on the ACA exchanges. Our analysis found that the average state will see a 41 percent increase in underlying premiums, prior to the impact of subsidies. Among the states seeing large increases are North Carolina (136%), Georgia (92%), Michigan (66%), Louisiana (53%), Kentucky (47%), and Illinois (43%). Our analysis did find that eight states will see average premiums decrease under the law, including New York (-40%) and New Jersey (-19%).

Of the six categories we studied, 27-year-old men face the steepest increases, with an average hike of 77 percent. 40-year-old women see the mildest increases, with an average of 18 percent.

Subsidies will mainly benefit the elderly

We also studied the impact of the law's premium assistance payments on exchange premiums. Our analysis found that, for individuals of average income, taxpayer-funded insurance subsidies primarily flow to those nearing retirement. This is because the elderly will still pay more for insurance, on average, than younger individuals, and because the subsidies are designed to fix the percentage of one's income devoted to paying health insurance premiums.

Taking subsidies into account, 64-year-old men will pay on average 19 percent less for insurance under the ACA system, whereas 27-year-old men will pay 41 percent more.

Adverse selection is likely to occur

The Manhattan Institute analysis indicates that we are indeed likely to see a fair amount of adverse selection on the exchanges. People who consume an above-average amount of health care services, such as sicker and older individuals, have a compelling economic incentive to enroll on the ACA marketplaces. Healthier and younger individuals have less of an incentive, even when one takes the individual mandate into account.

While many in the press are focused on the exchange enrollment figures that HHS released yesterday, what's more important than the *number* of people who enroll in the exchanges is the *composition* of the people who enroll in the exchanges. This will give us a sense of whether or not marketplace premiums are likely to further increase in 2015 and 2016, exacerbating the problem of adverse selection.

H.R. 3362, the Exchange Information Disclosure Act, would require HHS to provide weekly updates on exchange enrollment statistics. A greater degree of transparency and regular disclosure from HHS would be a desirable outcome. I would encourage the Health Subcommittee to consider the importance of requiring HHS to disclose the kind of information that would help us monitor adverse selection; that is to say, indicators of health status, such as age.

Higher deductibles and narrower networks

Our analysis did not directly examine the degree to which exchange-based plans have higher deductibles and narrower provider networks relative to plans available in 2013. There have been, however, many anecdotal reports of people paying higher premiums for plans with higher deductibles and narrower physician networks than the plans they previously enjoyed.

It is not inherently a bad thing for individuals to choose plans with higher deductibles and narrower networks, especially if those choices allow Americans to reduce their monthly premiums. However, in the case of the ACA, many individuals are reporting higher premiums for less attractive health coverage.

Chairman Upton has introduced a bill, H.R. 3350, that would allow individuals who wish to continue the coverage they enjoyed in 2013 to do so in 2014. This bill would almost certainly reduce the cost of coverage for millions of individuals, relative to the rate increases they would experience under the ACA. Ideally, Congress ought to modify the regulatory structure of the exchanges, in order to reduce as much as possible the

degree to which the ACA increases the underlying cost of individually purchased health insurance.

It would be one thing if the ACA was forcing Americans off of their old health insurance policies and offering them more attractive plans at a lower price. But millions of Americans are likely to see less attractive coverage at a higher price. If they do, then the Affordable Care Act will not live up to its name, and its goal of near-universal coverage will remain unfulfilled.

I look forward to your questions, and to being of further assistance to this committee.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize Ms. Corlette, 5 minutes for an opening statement.

STATEMENT OF SABRINA CORLETTE

Ms. CORLETTE. Good morning, and thank you. My name is Sabrina Corlette, and I am a Senior Research Fellow at Georgetown University's Center on Health Insurance Reforms. In my testimony today I will focus on two issues; how the individual health insurance market works today for consumers and the recent spate of so-called policy cancellations.

The ACA focuses its reforms on the individual market because of its well-documented systemic problems, which include a lack of access to coverage, unaffordable coverage, and inadequate coverage. Today 48 million Americans are uninsured, and 11 million have individual coverage. Those who buy insurance on their own can be self-employed entrepreneurs, farmers, and ranchers, early retirees, and young people aging off their parents' plans.

What does this health insurance market look like for these folks, particularly those who are in less than perfect health? Prior to the ACA insurers managed costs through aggressive underwriting to deny coverage to people with pre-existing conditions. People with even minor health issues such as hay fever could be turned down, and many individuals, even if they are offered a policy, are charged more because of their health status, gender, or age. Even those who enter the market in perfect health can find that premiums become unaffordable over time.

As for the adequacy of individual market coverage, it is generally abysmal. In many States insurers are permitted to permanently exclude from coverage any health problems that a consumer discloses, and many policies exclude, as a matter of course, critical benefits such as maternity, mental health, and prescription drugs. Individual policies also come with high deductibles. Ten thousand dollars or more is not uncommon. Individual policyholders report far more problems paying both premiums and out-of-pocket costs compared to people covered under group plans today.

There has been a lot of attention lately on people with individual health insurance receiving policy cancellations from their insurance companies. First, having an insurance company cancel a policy is nothing new. Insurance companies have long been able to discontinue individual insurance policies when it is no longer in their business interest to maintain them. They have also long been able to hike premiums and modify coverage.

Second, the ACA doesn't require insurers to drop policies. Rather, it requires individuals to have insurance that meets the basic minimum standards. Individuals who first purchased their policy after March 23, 2010, will be required to transition to new coverage that meets these standards.

Anticipating the need for their policyholders to make this transition insurers have taken different approaches. Some have offered an opportunity to early renew so that policyholders can remain in their current coverage for up to one more year, some have notified policyholders they will need to transition to new coverage, and some have decided to discontinue some of their current policies at

the end of this year and notified policyholders so they can take advantage of open enrollment on the exchanges.

Had the exchange Web sites been operable on October 1, the reaction to insurer notices likely would have been much less dramatic than it has been. Consumers who received these notices have been justifiably alarmed, particularly when the insurer notice does not lay out all of their new coverage options or provide estimates of the subsidies for which millions will be eligible. Hopefully soon all the Web sites will be working so that consumers can see these new coverage options that will likely be a better value than anything they have been able to get on the individual market.

Unfortunately, some policy proposals such as the bill introduced by Chairman Upton would actually make the problem worse. First, Mr. Upton's bill doesn't actually address the problem it purports to solve. Nothing in it prohibits insurers from discontinuing policies they don't want to maintain.

Second, by segmenting the risk pool between the healthy and the less healthy, the bill will set up an insurance debt spiral resulting in higher premiums and less choice for millions of Americans.

Mr. Chairman and members of this committee, the current health insurance market does not work for the people who need it the most. What we have had is a system of haves and have nots, and even if you have insurance, you still cannot have peace of mind because today's insurance market may offer low teaser rates to some, but it can't sustain affordability of coverage over time as people inevitably age or get sick.

Instead, this market is likely to fail people just when they need their coverage the most. Congress recognized the fundamental injustice of the current system, and it enacted important reforms that over time will improve Americans' access to adequate and more affordable coverage.

I look forward to your questions.

[The prepared statement of Ms. Corlette follows:]

STATEMENT OF
SABRINA CORLETTE, SENIOR RESEARCH FELLOW
GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE
CENTER ON HEALTH INSURANCE REFORMS

HEARING ON IMPLEMENTATION OF THE AFFORDABLE CARE ACT
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH

NOVEMBER 14, 2013

Good morning, Mr. Chairman, Ranking Member Pallone, Members of the Committee. I am Sabrina Corlette, a Senior Research Fellow and Project Director at Georgetown University's Center on Health Insurance Reforms. I am responsible for directing research and analysis on health insurance, health insurance markets, and implementation of the Patient Protection and Affordable Care Act (ACA).

I thank you for the opportunity to testify before you today, and for the leadership of this Committee in conducting ongoing oversight of the implementation of the ACA. This hearing today is a timely one, as we are now slightly less than 6 weeks into open enrollment into health plans that will meet sweeping new standards for access, affordability, and adequacy.

In my testimony, I will focus on how the individual health insurance market has worked until now for consumers, and how it will change upon implementation of the ACA's market reforms, some of the most significant of which go into effect on January 1, 2014. The ACA has a particular focus on the individual market because of its well-documented systemic problems, which include:

1) Lack of access to coverage because of health status discrimination
2) Inadequate coverage
3) Unaffordable coverage
4) Lack of transparency and accountability

Having affordable, adequate health insurance coverage is essential to the health and financial vitality of American families. People without health insurance are significantly less likely to receive necessary care, and a lack of meaningful coverage has resulted in medical debt being a primary cause of personal bankruptcies.[1]

Yet today, approximately 48 million non-elderly Americans are uninsured, and approximately 11 million Americans under age 65 obtain their health insurance through the individual market, meaning they do not have coverage through their employer or public programs such as Medicare and Medicaid. Anyone can find themselves at any time in the position of being uninsured, or required to buy coverage in the individual market. A recent survey found that in 2012, 30 percent of adults under age 65 did not have health insurance for some period of time.[2] And people who buy health insurance on their own can be self-employed entrepreneurs, farmers and ranchers, early retirees, part-time workers, widows, and young people "aging off" their parents' plans. The individual market tends to be a last resort when people do not have an offer of employer-based coverage or are ineligible for public coverage. As *Business Insider* magazine recently put it, the individual insurance market is a "basket case."[3]

To date the individual market has been an inhospitable place, particularly for people in less than perfect health.[4] That's a lot of us. According to one estimate, between 50 and 129 million non-elderly Americans have at least one pre-existing condition that would threaten their access to health care and health insurance.[5] These include a wide range of conditions, from back pain and prior sports injuries to chronic illnesses such as diabetes and asthma, as well as diseases like cancer. But until now, in most states, applicants for health insurance can be denied a policy because of their health status, or charged more in premiums based on their health and gender, along with a number of other factors. Insurers can also issue policies that don't cover critical medical services like pharmacy benefits, mental health benefits, maternity coverage or any of the care required to treat a person's pre-existing condition. And before enactment of the ACA in 2010, insurers could – and did – drop (or rescind) an individual's coverage if they got sick, and often imposed annual and lifetime dollar limits on covered benefits.

The ACA includes numerous reforms intended to address the shortcomings in the individual market. These set a minimum federal standard for an individual's access to affordable and adequate health insurance, with state flexibility to enact stronger consumer protections if they wish.

The ACA has already begun improving people's coverage options, and how it will continue to improve access to health care and families' financial security when all the reforms are in full effect.

AVAILABILITY OF COVERAGE

Until the ACA is fully implemented, one of the many ways health insurers are able to maximize revenue is to make use of aggressive underwriting practices to deny coverage to individuals with pre-existing conditions.[6] In most states, when an individual wants to buy health insurance, they must fill out and submit a voluminous application that includes detailed information about their health history and status.[7] Insurers then "underwrite" the application by reviewing the individual's health history and assessing the likelihood he or she will incur future health costs. A Georgetown University study from 2001 found that even people with minor health conditions, such as hay fever, may be turned down for coverage, and more recent studies have found that these practices have only increased over time.[8],[9] Health insurers maintain underwriting guidelines that can list as many as 400 medical conditions as reasons to trigger a permanent denial of coverage.[10]

According to a study by the U.S. Government Accountability Office (GAO), average denial rates in the individual market are 19 percent, but they can vary dramatically market-to-market and insurer-to-insurer.[11] For example, across six major health insurers in one state, denial rates ranged from 6 to 40 percent. Unfortunately, access is probably even more difficult for people

with health conditions than these data suggest, because of a common industry practice known as "street underwriting," in which an insurance company agent or broker asks a consumer questions about their health history and steers them away from the plan before they fill out or submit an application.

Under the ACA, insurers are required to provide coverage to people who apply for it, regardless of their health status. This provision went into effect for children under age 19 in 2010, and for all individuals applying for coverage starting January 1, 2014.

The ACA also prohibits insurance companies from rescinding the coverage of consumers who submit medical claims. Prior to the enactment of this provision, which went into effect in September of 2010, insurers in many states would investigate individual policyholders who made claims in their first year of coverage. If the company found evidence that their health condition was a pre-existing one, and not fully disclosed during the initial medical underwriting process, the company could deny the relevant claims, and in some cases cancel or rescind the coverage.[12] Under the ACA, this practice is now illegal except in a clear case of fraud by the policyholder.

AFFORDABILITY OF COVERAGE

Health insurance is an expensive product, and it is particularly expensive for people trying to buy it on the individual market. Unlike those with employer-sponsored coverage or in public programs like Medicare or Medicaid, people with individual insurance must pay the full cost of their premium. According to one national survey, among people buying insurance on their own, 31 percent spent 10 percent or more of their income on premium costs, compared to only 13 percent of people in employer-based coverage.[13]

For many, the cost of premiums can cause them to forego coverage completely. A national survey found that nearly three-quarters (73%) of people seeking coverage in the individual market did not end up buying a plan, most often because the premium was too high.[14] And coverage is the least affordable for people who need it the most – those with pre-existing conditions. The same national survey found that 70 percent of people with health problems reported it "very difficult" or "impossible" to find an affordable plan, compared with 45 percent of people in better health.[15]

More often than not, a common life event causes people to lose coverage or enter the individual market – losing or changing jobs, an illness, a divorce, a birthday, or a move. Prior to enactment of the ACA, consumers had some protections to help them transition to new coverage, although those protections were often inadequate. These "safe harbors" under federal law include COBRA, which allows those who lose access to job based coverage to continue their coverage in their former employer's plan for 18-36 months, and HIPAA, which

was designed to help people obtain a health insurance policy after their COBRA coverage ends. However, these safe harbors have often not been helpful because premiums are priced out of reach, or the coverage offered is inadequate. For example, in most states HIPAA premiums are quite high, and the federal law does little to regulate the content of coverage, allowing insurers to offer bare-bones policies. And while COBRA helps provide a bridge for people leaving employment-based coverage, enrollees can be required to pay the full premium, including the portion their former employer paid, plus an administrative fee. For families who no longer have income from a job, that cost can be prohibitive.

And, in the individual market, older and less healthy individuals have had to pay more because health insurers manage costs by segmenting their enrollees into different groups and charging different prices based on health or other risk factors.[16] In practice, this means that people can be charged more because of a pre-existing condition (even if they've been symptom-free for years), because of their age, gender (women are assumed to use more health care services), family size, geographic location, the work they do, and even their lifestyle. A Georgetown University study of rating practices in states with little rate regulation found rate variation of more than nine-fold for the same policy based on age and health status.[17] People in their early sixties can be charged as much as six times the premium of people in their early twenties, based on age alone. Even young people, when rated based on health status, can be subject to significant costs for coverage. At the same time, those few lucky individuals who have no health problems are, in effect, paying artificially low premiums and profiting from a system that locks out the sickest and forces people with even minor health conditions to pay more.

For older individuals, women, and people with pre-existing conditions, their premiums will become more affordable beginning in 2014. Under the ACA, using health status and gender to set premium rates is prohibited. Insurers are permitted to use only the following factors in setting premiums: age (limited to 3 times the premium of a young person), tobacco use, geographic location, and family size.

And even though they tend to be healthy, many young adults have been unable to afford health insurance in the individual market, particularly as many are just launching careers and work in part-time or other jobs that do not offer health coverage. However, many young adults are newly gaining access to more affordable coverage because of a provision of the ACA allowing them to stay on their parents' health plans up to age 26. This provision, which went into effect in 2010, has helped lead to a significant decline in the number of young adults who are uninsured: from 13.6 million in 2010 to 11.7 million in 2012, a decline of 1.9 million.[18]

More significantly, many of these young adults and millions of other Americans will soon gain access to premium tax credits that will help make coverage more affordable. And

approximately 48 percent of people currently covered through individual health insurance policies will qualify for a premium tax credit, with an average credit of $2700.[19]

ADEQUACY OF COVERAGE

Currently, the insurance coverage available to individuals buying it on their own falls far short of the typical employer-based plan. In addition to paying higher premiums, people buying individual policies face limited benefits and much higher deductibles and other forms of cost-sharing, such as co-payments and coinsurance. They also spend a much larger share of their income on health insurance and health care than those with employer-sponsored coverage.[20] A Commonwealth Fund survey found that 60 percent of people with health problems reported it very difficult or impossible to find a plan with the coverage they needed, compared to about one-third of respondents without a health problem.[21]

The number of "underinsured" individuals has risen dramatically over the last decade, such that there are nearly twice as many today as there were in 2003. Further, individuals purchasing coverage on their own were more than twice as likely to be underinsured as those who had coverage through an employer-based plan.[22] In general, someone is considered underinsured when they have insurance but because of high deductibles, high co-payments, or non-covered benefits, the insurance offers inadequate financial protection for the health care services people need.[23]

One primary reason people buying individual insurance coverage can have high out-of-pocket costs is that many individual market plans - over half according to one study – do not meet the minimum standard of coverage provided for under the ACA.[24] Coverage in the individual market today can be inadequate for many reasons, including:

Pre-existing condition exclusions. In many states, insurers are permitted to permanently exclude from coverage any health problems that a consumer discloses on their application for an individual policy. In addition, once coverage begins, if a consumer makes claims under the policy, he or she can be investigated to see whether the health problem was pre-existing. In many states, it's not necessary for a health condition to have been diagnosed before the consumer bought the policy for it to be considered "pre-existing." And insurers can look back into a person's health history to determine whether the current condition was pre-existing. This is sometimes called "post-claims underwriting."

Under the Affordable Care Act, pre-existing condition exclusions were prohibited for individuals under age 19 in 2010, and will be prohibited for all individuals beginning in January of 2014. People will be able to access the care they need from their first day of coverage.

Limited Benefits. Insurers selling health insurance in the individual market often sell "stripped down" policies that do not cover benefits such as maternity care, prescription drugs, mental health, and substance abuse treatment services. For example, 62 percent of individual market enrollees do not have coverage for maternity services, 18 percent lack mental health services coverage, and 9 percent do not have coverage for prescription drugs.[25]

To improve the value of coverage, the ACA sets a minimum benefit standard that insurers must cover. This "essential health benefits" package requirement is designed to ensure that consumers have comprehensive coverage that meets their health needs and protects them from financial hardship. These essential health benefits are expected to be included in the coverage of up to 68 million Americans by 2016 and will include – at a minimum – 10 categories of benefits: ambulatory patient services (i.e., doctor visits); emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.[26] The essential health benefits give individuals and small employers assurance that their benefits will meet a minimum standard for adequacy.

Lifetime and Annual Limits. Prior to enactment of the ACA, it is estimated that about 102 million people were in plans with a lifetime limit on benefits and about 20,000 people hit those limits every year. And 18 million people were in plans with annual dollar limits on their benefits. Those limits can be a matter of life and death.

The Affordable Care Act ushered in a ban on lifetime limits, and put immediate restrictions on annual dollar limits (banning them completely in 2014).

High Out-of-Pocket Costs. Individual policies often come with high deductibles - $10,000 or more is not uncommon – and high cost-sharing. In fact, deductibles can be about three times what they are in employer-based plans.[27] As a result, many of these plans are very low value, below the minimum standard in the Affordable Care Act.[28] One study in California found that individual policies pay for just 55 percent of the expenses for covered services, compared to 83 percent for small group health plans.[29] Thus, these policies have fewer covered services and cover a smaller share of the costs associated with the services they do cover. It is not surprising then that medical debt is a primary cause of personal bankruptcies, with an estimated 20 percent of Americans reporting problems paying medical bills. Of those, approximately 40 percent had some form of health insurance.[30] Medical debt can have significant, long-term financial consequences for families. Many lose their good credit, eat up retirement savings to pay off debt, or take on credit card debt at high interest rates.[31]

For the first time, the ACA sets new standards to ensure that insurance coverage does what it should: provide real financial protection to individuals and families. The law sets coverage levels, with Platinum plans being the most generous (enrollees will pay, on average, 10 percent of the out-of-pocket costs) and Bronze plans being the least generous (enrollees will pay, on average, 40 percent of the out-of-pocket costs). The ACA also sets new limits on the total amount of out-of-pocket spending consumers must incur, based on their income. For 2014, those limits are set at $6,350 for individuals and $12,700 for families. In addition, for individuals earning up to $28,725 annually (up to $58,875 for a family of four), the ACA provides cost-sharing subsidies that will reduce their out-of-pocket spending.

TRANSPARENCY OF COVERAGE

Transparency and accountability are critical to a well-functioning insurance marketplace. Shopping for health insurance is a complex and confusing task for consumers, most of whom do not understand important components of the products being sold to them, or how their coverage works. For people shopping on the individual market, they must undergo medical underwriting, which requires them to complete voluminous application forms, and agree to allow insurers to investigate their medical history. Health insurance policies are written in legalese and difficult for even highly educated consumers to understand. It is little wonder that Americans rate reading up on their health insurance policy as a less appealing activity than preparing their income taxes or going to the gym.[32]

Prior to enactment of the Affordable Care Act, individuals attempting to buy insurance coverage in the individual market faced confusing choices, with little transparency about what their policy would actually cover – and what it would not. They have had almost no ability to effectively compare health plans on an apples-to-apples basis.

The ACA ushers in a number of critical changes to improve consumers' ability to shop for and compare plans in a manner that allows them to make informed choices and select a plan that best meets their needs. First, it creates state-based health insurance exchanges, or "marketplaces," that will help consumers make apples-to-apples comparisons among health plan options, and allow them to shop with confidence, knowing that all participating plans have met minimum quality standards.

In addition, the ACA requires insurance companies to provide a new Summary of Benefits and Coverage. These standardized, easy-to-read summaries of the benefits, cost-sharing, limitations and exclusions in a plan can help consumers understand their coverage and make better choices. Consumer testing by Consumer Reports has found that consumers rated their Summary of Benefits and Coverage more helpful than other sources of plan information, such as employer guides and health insurers' brochures.[33]

The law also includes new expectations for insurer accountability. The law improves state rate review practices, and authorizes the federal government to review unreasonable rate increases if a state is unwilling or unable to do so. Insurers proposing new premium rate increases must provide detailed and public justification for those increases. Insurers must also spend at least 80 percent of individual market premiums on health care and improving health care quality. If they don't meet that standard, they must issue rebate checks to enrollees. This policy was in effect for 2011, and in 2012 nearly 12.8 million Americans received rebates totaling more than $1.1 billion.[34] The aggregate amount of rebates declined in 2013, to $504 million, largely because insurers are beginning to moderate their premium increases and operate more efficiently. As a result, an estimated 77.8 million consumers are saving $3.4 billion in up front premium costs.[35]

ADDRESSING POLICY "CANCELLATIONS"

There has been a lot of breathless journalism lately about people with individual health insurance policies receiving policy cancellations from their insurance companies. First, having an insurance company cancel a policy is nothing new. Insurance companies have long been able to discontinue individual insurance policies when it is no longer in their business interest to maintain them. They've also long been able to hike premiums and modify coverage for current policyholders by changing provider networks and drugs covered under their formularies.

Second, the ACA doesn't require insurers to drop policies. Rather, it requires individuals to maintain insurance that meets basic standards. The ACA also specifies that enrollment in a grandfathered plan satisfies the requirement to have health coverage. Individuals who first purchased their policy after March 23, 2010, will be required to transition to new coverage that meets new market standards as their current policy reaches its anniversary date, on or after January 1, 2014.

Anticipating the need for their non-grandfathered policyholders to make this transition, insurers have taken different approaches: (1) some have offered an opportunity to "early renew" so that non-grandfathered policyholders can remain in current coverage for up to one more year; (2) some have notified non-grandfathered policyholders they will need to transition to new coverage as their current policy approaches the anniversary date of coverage; (3) some have decided to discontinue some of their current policies as of December 31, 2013 and have notified policyholders so they could take advantage of Open Enrollment and carefully review new health plan options and the new financial assistance that will be available.

Had the exchange websites been operable on October 1, the reaction to insurer notices likely would have been much less dramatic than that reported in the press. But consumers who receive these notices have been justifiably anxious and alarmed, particularly when the insurer

notice doesn't lay out all the new coverage options or provide estimates of subsidies for which millions of policyholders will be eligible. Hopefully soon, all exchange websites will be working smoothly and efficiently so that consumers can see a new set of coverage options that will likely be a better value than anything they have been able to obtain on the individual market.

Unfortunately, some policy proposals to help these individuals – such as the bill introduced by Chairman Upton – would actually make the problem worse. First, Mr. Upton's bill doesn't actually address the problem it purports to solve. Nothing in it prohibits insurers from discontinuing policies they don't want to maintain. Second, by segmenting the risk pool between healthy and less-healthy, this bill will set up an insurance "death spiral" for the exchanges, resulting in higher premiums and less choice for millions of Americans.

CONCLUSION

The insurance marketplace as it exists before full implementation of the ACA does not work for the people who need it most. Anyone with any health condition at any point in their lives can face difficulty obtaining insurance coverage, particularly in the individual insurance market. People in this market have problems with access, with affordability, and, if they can obtain a health insurance policy, it is often not adequate to meet their needs. In addition, until enactment of the ACA, the complex and confusing process of comparing and buying plans discouraged many consumers from obtaining coverage.

The ACA ushers in common-sense reforms that will soon improve Americans' experience buying insurance and, most importantly, provide them with more meaningful access to health services and help protect them financially when they get sick or injured. These changes are transformative – and some changes will cause some disruptions, particularly for young, healthy individuals. But over time, millions of Americans will benefit from a system that is fairer and more accountable.

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Mr. PITTS. The Chair thanks the gentlelady and now recognizes Reverend Dixon Hill. Five minutes for an opening statement.

Do you want to turn on the mike, please, or pull it closer?

Ms. DIXON HILL. Can you hear me?

Mr. PITTS. That is good.

STATEMENT OF MARILYN DIXON HILL

Ms. DIXON HILL. Good morning. Chairman Pitts, Ranking Member Pallone, and members of the Health Subcommittee, thank you.

My name is Reverent Marilyn Dixon Hill. I am a registered nurse for almost 30 years and currently serve as an associate pastor at Camden Bible Tabernacle Church in Camden, New Jersey. Camden has been my home for 40 years, and I am very active in the community, especially as a clergy leader with Camden Churches Organizing for People, CCOP, an affiliate of PICO National Network with more than 1,000 member institutions representing 1,000,000 families in 17 States and PICO is the fastest and growing network of faith-based community organizations in the country. Today I am here to share my story with you as a representative of PICO and the hundreds of thousands of people of faith who belong to our network.

The value of people being able to access care is very real to me. That day, November 10, 2010, will be a day I will remember forever. On that day almost exactly 3 years ago I received what should have been a routine flu shot, but that shot ended up being anything but routine. Due to a very rare side effect I became completely paralyzed and nearly died. Although I have recovered somewhat, I am disabled and live with Guillain-Barre Syndrome.

Although there are many lessons I learned from this challenging time in my life, the one that brings me here today was my firsthand experience with how broken our healthcare system was. When I was released from rehabilitation, that is, finally able to sit up and even stand for short periods of time, I discovered that I could not financially afford to continue my care. Paying for COBRA was too expensive, and my disability benefit was too high to qualify for Medicaid. In short, the very health insurance that would have made it possible for me to continue to rehabilitate and eventually enter back into the workforce was unavailable to me.

I spent 2 years in this painful gap before finally qualifying for coverage through Medicare. Sadly, many going through health coverage challenges like this never made it to getting the care that they need, and that was the case for one of our congressional members, Ronald Butler, 56-year-old uninsured man who died from a brain tumor. Despite two trips to a hospital, Ronald's tumor went undetected until a week before he died, all because he didn't have health insurance.

Truly, it is tragic for both Ronald and me to have such serious problems, but the real tragedy is it didn't have to be as painful, as terrifying, and isolating as it was. Our lives could have been improved, sustained, and in Ronald's case, even saved if he had received the care that he needed and ought to have had.

My experience, echoed in the experiences of so many in Camden and throughout the United States, that is what motivated me to get involved in reforming our healthcare system, and my firm belief

that we are all called to love one another and to care for one another inspires me every day to ensure that everyone has access to the affordable care that they need.

Now with the Healthcare Act being fully implemented, my community and communities like mine across America are mobilizing to bring affordable care to the people who need it most. We are bringing enrollment opportunities to our congregations, to food pantries, schools, and our neighborhood because we know there is a hunger and a deep need for health insurance. Accessing affordable care strengthens our communities. It helps us thrive, and it is good, sound economics for our countries.

The ACA implementation Medicaid enrollment is up. Yes, we expected that. It shows that the bill got it right and is working to get people living without health insurance the coverage that they need.

October the 24th in Camden alone the Camden County Board of Social Services received 609 direct applications, at least 134 of which would not have been eligible for Medicaid.

Secondly, we know from our lived experiences and substantial research that a healthier society is a more productive society. Look no further than my own story. My lack of access to affordable care prevented my full rehabilitation and return to working as a nurse.

Mr. Chair, Ranking Member Pallone, and members of the Health Subcommittee, access to affordable healthcare saves lives, supports communities and families, and helps communities thrive. For we are all our brother's keeper.

Thank you for your time today and the opportunity to speak with you.

[The prepared statement of Ms. Dixon Hill follows:]

Testimony to the U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health
"Obamacare Implementation Problems: More than Just a Broken Website"
November 14, 2013

Testifier: Reverend Marilyn Dixon Hill
Organization: PICO National Network
Contact: Elianne Farhat (612-250-8087, efarhat@piconetwork.org)

Chairman Pitts, Ranking Member Pallone and members of the Health Subcommittee:

My name is Reverend Marilyn Dixon Hill. I was a registered nurse for 30 years and currently serve as Associate Pastor at Camden Bible Tabernacle Church in Camden, New Jersey. Camden has been my home for 40 years and I am very active in my community, especially as a clergy leader with Camden Churches Organizing for People (CCOP) – a PICO National Network affiliate. With more than 1,000 member institutions representing one million families in 17 states, PICO is the largest and fastest growing network of faith-based community organizations in the country. Today, I am here to share my story with you as a representative of PICO and the hundreds of thousands of people of faith who belong to our network.

The value of people being able to access care is very real to me. The day November 10, 2010 will be a day I remember forever. On that day, almost exactly three years ago, I received what should have been a routine flu shot – but that shot ended up being anything but "routine." Due to a very rare side effect I became completely paralyzed and nearly died. Today, although I have recovered somewhat, I am disabled and live with Guillain-Barré syndrome.

Although there are many lessons I learned from this challenging time in my life, one that brings me here today was my firsthand experience of how broken our health care system was. When I was released from rehabilitation – finally able to sit-up and even stand for short periods of time – I discovered that I could not financially afford to continue my care. Paying for COBRA was too expensive for my tight budget and my disability benefit was too high to qualify for Medicaid. In short, the very health insurance that would have made it possible for me to continue to rehabilitate, and eventually enter back into the workforce, was unavailable to me.

I spent two years caught in this painful care gap before finally qualifying for coverage through Medicare. Sadly, many going through health coverage challenges like these never make it to getting care the care they need. That was the case for Ronald Butler – an uninsured 56 year-old former member of my congregation who died from a brain tumor. Despite two trips to the hospital, Ronald's tumor went undetected until a week before he died – all because he lacked insurance for proper testing.

Surely it was tragic for both Ronald and me to have such serious health problems, but the true tragedy is that it didn't have to be as painful, terrifying and isolating as it was. Our lives could

have been improved, sustained, and - in Ronald's case – even saved, if we had received the care we needed and ought to have had.

My experience – echoed in the experiences of so many in Camden and throughout the United States – motivated me to get involved in reforming our health care system. And, my firm belief that we are all children of God and are called to love and care for all those in His beloved community, inspires me every day to ensure everyone has access to the affordable care they need.

Now, with the Affordable Care Act (ACA) being fully implemented, my community and communities like mine across America are mobilizing to bring affordable care to the people who need it most. In doing so, we are beginning to heal from years of avoidable tragedies.

We are bringing enrollment opportunities to our congregations, to our food pantries, to our schools, and to our neighborhoods because we know that (1) there is a hunger and deep need for health insurance among our people, (2) accessing affordable care strengthens our communities and helps us thrive; and, (3) it is good, sound economics for our cities and states.

First, as we have seen in media coverage and reports on the progress of ACA implementation, Medicaid enrollment is up – just as was expected. This is a good thing! It shows that the bill got it right and is working to get people living without health insurance the coverage they need. As of October 24, in Camden alone, the County Board of Social Services received 609 direct applications – at least 134 of which would not have been eligible for coverage before the ACA. That is 134 people just like me and families just like mine who are receiving the benefit and security of comprehensive, affordable health insurance for the first time in a long time – maybe even the first time ever.

Second, we know both from our lived experiences and from substantial research, that a healthier society is a more productive society. You need look no further than my own story – my lack of access to affordable care prevented my full rehabilitation and return to working as a nurse.

Another example of this is the findings from Oregon that showed families receiving Medicaid coverage under their state's expansion saw catastrophic health costs essentially disappear. Health insurance, and especially Medicaid due to the populations it serves, helps low-income families move beyond living paycheck-to-paycheck and begin to move out of poverty. Affordable and accessible coverage is an essential ingredient in living the full, productive, healthy life God intended for each of us to live.

Finally, third, Medicaid programs are good for our local economies. Not only, as I just mentioned, does it keep people from drowning in catastrophic medical debt, but it is also a proven economic stimulator. And, with the federal government covering up to nearly 92 percent of the cost of Medicaid expansion over its first 10 years, the cost to state and local

governments has the potential to be completely offset by savings in state programs that serve uninsured people.

Governors, chambers of commerce, and hospital associations across the United States – from New Jersey to Ohio to New Mexico to California – are clear on this benefit and are joining with faith and community organizations to bring the full benefits of the Affordable Care Act to every state in the country.

Mr. Chair, Ranking Member Pallone, and members of the Health Subcommittee, access to affordable health care saves lives, supports families, and helps communities thrive. The Affordable Care Act, with its spectrum of coverage options, is intentionally designed to meet the needs of every American – regardless of where you live or how much money you have. High rates of enrollment in Medicaid are a sign that people in need are getting the coverage we planned for. I see this, and I hope you will too, as a sign of hope and healing and God's love at work in our country.

Thank you for your time today and the opportunity to speak with you.

Mr. PITTS. The Chair thanks the gentlelady.

I now recognize Dr. Stark, 5 minutes for an opening statement.

STATEMENT OF ROGER STARK

Mr. STARK. Good morning. Chairman Pitts, Ranking Member Pallone.

Mr. PITTS. Pull the mike towards you a little bit.

Mr. STARK. Good morning, Chairman Pitts, Ranking Member Pallone, members. I thank you for the opportunity this morning to testify before your subcommittee.

Washington State has been very proactive about establishing a State health insurance exchange and about expanding our Medicaid Program as allowed by the Affordable Care Act. Our State exchange opened for enrollment on October 1. We anticipate that ultimately we will see 320,000 to 400,000 enrollees in the new expanded Medicaid Program.

As of October 31 our exchange had a total of 105,000 applicants with 70,000 of these in the new Medicaid Program. This represents 67 percent of the total. Of these applicants 55,000 completed the enrollment process with 48,000 of these completions in the new Medicaid. This represents 87 percent of the total. In other words almost 90 percent of completed applications were done in the new Medicaid Program where no upfront premium fee is required.

Although the ACA is written such that State taxpayers will eventually pay only 10 percent of the cost of the new Medicaid, it should be noted that State taxpayers are also Federal taxpayers. Medicaid is a pay-as-you-go entitlement. Therefore, Washington State taxpayers will ultimately pay for essentially the entire cost of the new Medicaid in our State, which is estimated to be 17 to $22 billion depending on enrollment over 10 years.

The ultimate consequence of this broad expansion of government into healthcare has been to crowd out private insurance. Over 20 percent of adults and 27 percent of children in the existing Medicaid already had private insurance at the time they enrolled. As Medicaid has expanded, it is now estimated that up to one-half of current new enrollees already have private coverage.

As employers, especially in low-wage industries, drop employee health benefits, this crowd-out effect will only get worse in the expanded Medicaid. There is also the phenomenon of the welcome mat or woodwork effect, and this is real because of increasing advertising, increasing public relation, patients who qualify for the existing Medicaid Program will potentially enroll in large numbers.

The Urban Institute looked at this on a State-by-State basis, and for Washington State they estimate that 545,000 new enrollees will occur in our existing Medicaid Program. This will be at a cost of $14 billion to the State of Washington taxpayers over 10 years.

In 2008, Oregon officials created the perfect test case on the effectiveness of Medicaid in providing healthcare. This had been a controlled, randomized study of people with and without Medicaid. The New England Journal of Medicine recently reported the results. It turns out that being put on Medicaid does not improve health outcomes, nor does it improve mortality statistics compared to having no health insurance coverage at all.

Medicaid is an extremely inefficient program, and reimbursement for doctors and other providers is about one half of what private insurance pays for the same services. Doctors are not able to pay their own overhead with these low payment rates, and consequently, our existing Medicaid patients have trouble accessing healthcare.

The Washington State Medical Association recently found that 18 percent of primary care providers had dropped all Medicaid patients and 24 percent were not taking new Medicaid patients because of poor provider reimbursement. Getting access to healthcare is a significant problem for people in the existing Medicaid Program in our State.

Like any entitlement program, Medicaid encourages overutilization. The tragic irony is that because of low provider reimbursements access for patients is severely limited. All Medicaid patients by definition have health insurance, but just having health insurance does not guarantee one will receive healthcare services.

Another tragedy is that after more than 40 years there is no evidence Medicaid has improved health outcomes for the vast majority of either children or adults enrolled in the program.

In conclusion, limited public safety net programs will always be needed to provide healthcare for the poorest and most vulnerable people in our society, however, the bloated and expanding Medicaid Entitlement Program, as it is presently structured, is not sustainable. Even though the new program will be funded by Federal taxpayers, costs will explode just as we have seen since 1965.

Thank you very much, and I look forward to your questions.

[The prepared statement of Mr. Stark follows:]

Congressional Testimony November 14, 2013

Roger Stark, MD, FACS

BACKGROUND

At the current rate of spending increase, funding of the existing Medicaid program will double compared to current levels in nine years, that is, by fiscal 2021. At an average growth rate of 8% a year, Medicaid is the fastest growing federal entitlement program. The Congressional Budget Office estimates that, without changes made to current policies, the existing Medicaid program alone will comprise almost 6% of the nation's gross domestic product by 2017. The Affordable Care Act (ACA) will add an estimated 16 - 23 million more patients to the "expanded" Medicaid and will only make this cost problem worse.

WASHINGTON STATE

Washington state has been very pro-active about establishing a state health insurance exchange. Our state exchange opened for enrollment on October 1st, and except for temporary, first-day problems, it has been successfully accepting applications. We anticipate that ultimately we will see 320,000 to 400,000 new Medicaid patients enrolled through the exchange.

As of October 31st, our exchange had a total of 105,000 applicants with 70,000 of these in the new Medicaid program. This represents 67% of the total.

Of these applicants, 55,000 completed the enrollment process with 48,000 of these completions in the new Medicaid. This represents 87% of the total.

In other words, almost 90% of completed applications were done in the new Medicaid program where no upfront premium fee is required. We have exchange board members who are calling this skewed enrollment pattern "Medicaid on steroids" with a huge "adverse risk selection."

Although the ACA is written such that state taxpayers will eventually pay only 10% of the cost of the new Medicaid, it should be noted that state taxpayers are also federal taxpayers. Medicaid is a pay-as-you-go entitlement. Therefore, Washington state taxpayers will ultimately pay for essentially the entire cost of the new Medicaid, or $17.8 – 22.2 billion over 10 years depending on enrollment.

MEDICAID CROWD OUT

The ultimate consequence of this broad expansion of government into health care has been to "crowd out" private insurance. Over 20% of adults and 27% of children in the existing Medicaid already had private insurance at the time they enrolled. Obviously, many people dropped their private coverage when seemingly "free health care" became available. As Medicaid has expanded, it is now estimated that up to one half of current new enrollees already had private coverage.

As employers, especially in low-wage industries, drop employee health benefits, this crowd out effect will only get worse in the expanded Medicaid.

IS MEDICAID BETTER THAN NO HEATLH INSURANCE ?

In 2008, Oregon officials held a lottery that ultimately signed up 6,400 new Medicaid enrollees. A further 5,800 people were eligible for the program, but were not selected. People in this group had the same health and economic profile as the lottery winners, allowing researchers to make valid comparisons. This created the perfect test-case on the effectiveness of Medicaid in providing care. These 5,800 people became the control group in the first, and to date only, controlled, randomized study of the effectiveness of Medicaid.

The *New England Journal of Medicine* recently reported the results. It turns out that being put on Medicaid does not improve health outcomes nor does it improve mortality statistics, compared to having no health insurance coverage at all.

ACCESS TO HEALTH CARE

Medicaid is an extremely inefficient program and reimbursement for doctors and other providers is about half of what private insurance pays for the same services. Doctors are not able to pay their own overhead with these low payment rates and consequently our existing Medicaid patients have trouble accessing health care.

The Washington State Medical Association recently found 18% of primary care providers had dropped all Medicaid patients and 24% were not taking new Medicaid patients because of poor payment and the complexity of treating Medicaid patients compared to privately insured patients. Getting access to health care is a significant problem for people in the existing Medicaid program in our state. It turns out having "insurance" is not the same as actually seeing a doctor.

Adding 16 to 23 million more people to Medicaid nationally and 320,000 to 400,000 in Washington state will make this access problem much worse.

LONG TERM MEDICAID CONCERNS

Many Medicaid reform proposals have been recommended through the years. Some of these, such as negotiating discounts for services, increasing provider fees to keep patients out of emergency rooms, and attempting to control drug costs, do not address the underlying problem of funding a broad health care entitlement.

Similarly, there is virtually no evidence that any of these ideas have significantly impacted the cost or the effectiveness of Medicaid. On the other hand, such initiatives as health savings accounts (HSAs), pursuing fraud aggressively, tightening eligibility requirements, and using block grants to states, have been shown to be effective in controlling costs.

The current Medicaid program is arguably the worst health insurance plan in the country. It has expanded massively beyond the original intent in 1965 and is now one of the two or three largest budget items for nearly every state. In spite of massive annual increases in spending, Medicaid chronically experiences budget-breaking costs. Expanding Medicaid, as the ACA requires, will only compound these problems.

Like any entitlement program, Medicaid encourages overutilization. The tragic irony is that because of low provider reimbursements, access for patients is severely limited. The number of doctors who are not seeing new Medicaid patients grows larger each year. All Medicaid patients, by definition, have health insurance, but just having health insurance does not guarantee one will receive health care services.

Another tragedy is that after more than 40 years, there is no evidence Medicaid has improved health outcomes for the vast majority of either children or adults enrolled in the program. Medicaid, like any entitlement that offers services apparently for free, has encouraged over utilization of health care resources. When services appear to be "free," the health care market has no ability to place a true value on that service and no way to know if limited resources are being allocated efficiently.

Limited public safety net programs will always be needed to provide health care for the poorest and most vulnerable people in our society. However, the bloated and expanding Medicaid entitlement program, as it is presently structured, is not sustainable. Even though the new program will be funded by federal taxpayers, costs will explode as we have seen since 1965. The federal government will then have only three choices, all of which are bad – run huge budget deficits, raise taxes, or ration medical care by limiting funding.

SUMMARY POINTS

1. The rising cost of Medicaid is not sustainable.
2. To date, the Washington state health exchange has enrolled a higher percent of Medicaid patients than anticipated and a much higher percent than non-Medicaid patients.
3. Medicaid crowds out private insurance.
4. Access to health care is an increasing problem for our existing Medicaid patients. The expansion of Medicaid in the Affordable Care Act will make this access problem worse.
5. There is now good evidence that having Medicaid does not improve health outcomes compared to not having insurance at all.

Mr. PITTS. The Chair thanks the gentleman. That concludes the opening statements. We will now go to questions and answers, and I will recognize myself 5 minutes for that purpose.

Mr. Roy, President Obama recently apologized to Americans in the individual market losing their current health coverage because of the Affordable Care Act. During a statement the President asserted that his broken promise would affect only a small portion of individuals, specifically stating that, "We are talking about 5 percent of the population."

Do you believe the President is being truthful when he states only 5 percent of the population will be affected by his broken, if you like your health plan, you can keep it, promise?

Mr. ROY. No, I don't believe that the President was making an accurate statement because people in the employer-sponsored market in particular will also see rate increases because of the ACA's——

Mr. PITTS. That was my follow-up question. Did the Affordable Care Act grandfathering regulation issued in the summer of 2010, contain any estimates for the number of Americans with employer-sponsored coverage that would lose grandfathered status?

Mr. ROY. In June of 2010 the Executive Branch estimated that 51 percent of employer-sponsored plans would lose grandfathering coverage. If you add that to the total of people who are also losing grandfathering coverage in the individual market, the total is 93 million Americans.

Mr. PITTS. Recently I received an e-mail from a constituent in Lancaster County, Nancy Soloff, who is trying to help a small business with four employees find affordable health coverage. Their small business received a cancelation notice stating that, "Enclosed you will find the January 1, 2014, renewal information for your group coverage. Please note that due to requirements of the Affordable Care Act your current benefit plan will no longer be available."

She went on to say, "In the news reports about the plans being eliminated they are only mentioning the individual plans. This is not true. Group plans are also being eliminated due to requirements of the Affordable Care Act."

Would it be fair to say that the President's promise of if you like your healthcare plan you can keep your health plan, won't be true for the tens of millions of Americans with employer-sponsored insurance like the workers in Lancaster County that I just mentioned?

Mr. ROY. I believe that would be a fair statement. Yes.

Mr. PITTS. Dr. Stark, looking ahead, States will have to weigh any decision to expand their Medicaid Programs against existing financial pressure to meet other State priorities such as education, economic development, public safety.

In addition, they must balance the pressure to better serve their existing Medicaid enrollees before over-expanding. Governors and legislators must recognize that every Medicaid dollar spent on an able-bodied, childless adult in the expansion population is potentially a future dollar diverted from the poorest and sickest children and seniors enrolled currently.

My home State of Pennsylvania is grappling with these questions now as they negotiate with CMS for greater flexibility to manage their program costs before an expansion.

What advice would you give the States who have waited to expand but will certainly be forced with this question again in their 2015 budget negotiations?

Mr. STARK. Well, I think each State has to look at their own individual situation, but clearly, expanding Medicaid on a State-by-State basis is still going to put a burden on the Federal Government. I think that States need to do is look at how they budget for their individual Medicaid Program and then allocate those dollars as wisely as they possibly can.

What we have seen over the last 45 years, 47 years in the Medicaid Program is it has grown dramatically such that it is now one of the top three budget items for every State in the country. In the State of Washington it is number two behind K through 12 education. So this clearly is a very impacting sort of impactful issue.

Mr. PITTS. Thank you. Commissioner Astrue, in your role as commissioner of Social Security Administration, you oversaw the replacement and expansion of the Social Security Administration's highly-ranked suite of electronic services, which included electronic services for retirement disability and Medicare.

Can you give us an overview of these projects, explain the process and the collaboration which occurred, how did the process and collaboration of the Affordable Care Act differ from your past projects?

Mr. ASTRUE. Thank you, Mr. Chairman. I think that is a good question. I think for a project as important as this one responsibility starts at the top. That did not happen at CMS, and although it is not glamorous and you don't get credit in the Washington Post for it, the leader of the agency has to sit down with a strongly-empowered team leader on a regular basis and go over what is the progress, what is the goal, what is the timeframe, and slog through it every 2 weeks, every 4 weeks until it is done, and that is what I did at Social Security, and we did a dozen of these major projects on my watch. And that way you have flow of information, you have your other team members there, you create an environment where people volunteer what the problems are, and you support the people who raise the problems, you deal with the problems early, and that is how you have success down the road.

Unfortunately, the CMS Plan is kind of like an NFL team showed up, and they said, well, you are all professionals, you all want to win the game, here is your play book, let's show up 3 days before the first game, and you can't win that way. And at CMS and HHS proper what didn't happen with those basic management techniques to get this kind of project done, and I think it is unfair to blame the contractors, blame the procurement process. Are there problems here? Yes. Did I sometimes have frustrations with some of those things? Yes, but are they a major part of the problem? No. The buck stops with the people who run the agency, and the political appointees do a disservice to the civil servants when they put all the blame on the civil servants, which isn't fair as well.

Mr. PITTS. Thank you. My time has expired.

I now recognize the ranking member for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

I guess I shouldn't be surprised that the Republicans are showing their true colors today and basically attacking Medicaid, but I think this whole thing is very ideologically driven. They don't like Medicaid, they don't want to expand Medicaid. I don't want to put words in their mouth, but some of them might even want to abolish Medicaid, and you know, Reverend Hill, I just wanted to thank you for your testimony about your struggles with the healthcare system and your efforts to help others get coverage, but one thing that is so frustrating about much of our discussion in this subcommittee is that we can't seem to agree on basic facts.

For example, we don't seem to agree on whether people signing up for coverage is a good thing or a bad thing. Now, in the first month of enrollment almost 1.5 million people have applied for coverage, and of those, 27 percent, or about 400,000 people, have been determined eligible for Medicaid for SCHIP, and this Medicaid enrollment is a good thing, not a bad thing. This is despite the fact that half the States haven't implemented Medicaid Expansion because of the intransigence of Republican governors. Again, ideologically based. Not practically based.

I do have to say, though, that usually I am critical of Governor Christie, but I do appreciate the fact that he expanded Medicaid in New Jersey, which is what makes it possible for you to talk about it in a positive way because we do have it in New Jersey.

But if individuals were eligible for Medicaid all along, it is a good thing that they finally enrolled. If they are newly eligible, that is a good thing, too. I don't think we should be disagreeing about people accessing benefits for which they are legally eligible.

Despite Dr. Stark's testimony, key studies have shown that having any type of insurance, including Medicaid, is better than having no insurance at all. It increases access to care, gives people financial peace of mind. If they are moving into Medicaid from private coverage, they are doing it because they are getting better value, better quality, or both.

You know, I bristle, Dr. Stark, when I hear you talk about this because taxpayers are paying when people are uninsured. They go to the hospital, they don't get care. You talk about overutilization. I would rather they go to the doctor, which is cheap, then they end up in the hospital which costs thousands of dollars. And so, yes, the taxpayers of the State are paying for it in some fashion, but they are going to be paying less in the long run because people get preventative care because they have coverage and they go to the doctor, and that is a good thing.

So Dr. Hill, in your experiences, is getting people Medicaid coverage a bad thing, or does it help improve their health and financial security?

Ms. DIXON HILL. Absolutely. When you have a patient that has insurance, they have a usual care source. So when they get sick, they can go and get care. If you are uninsured, you don't have a usual care source, and you are more likely to forego care, decide that I can't afford it, and end up in the hospital, which costs everybody money.

Mr. PALLONE. And, look, I will tell you again. If the Republicans think that—and Dr. Burgess said it that the reimbursement rate

is too low and that is why doctors don't want to take Medicaid, then raise the reimbursement rate. I don't hear an alternative here other than abolish it. Nobody said abolish Medicaid, thankfully, but that is what it seems to be saying.

Now, Professor Corlette, my Republican colleagues seem to think that, before reform, the individual health insurance market, the place where people go to buy coverage if they don't get it through their job, was a great place to be, but the fact is more than 50 percent of people left their coverage in this market after 1 year and over 80 percent left after 2 years, premiums could skyrocket if a person got sick, and many plans didn't cover key benefits like hospitalization. I was shocked to find out plans don't cover hospitalization. I mean, that is incredible.

Anyway, would you just tell us about people's ability to access coverage next year compared to before reform, and what can you tell us about changes in the stability and quality of coverage in the individual market post-reform?

Ms. CORLETTE. Sure. Thank you, Mr. Pallone, for the question.

The individual market before the Affordable Care reforms go into full effect is an extremely inhospitable place. As Business Insider magazine said recently, it is a basket case. Nobody is in the individual market unless they are forced to be there because they are in-between jobs, or they are self-employed, or they are an early retiree, and they haven't yet gained Medicare eligibility.

It is a place where you can be denied health insurance because you have a pre-existing condition. In fact, the GAO has said that between 9 and 40 percent of applicants are denied because they have some kind of health issue. You can be rated up because you have a health condition, and if you are able to get coverage, many plans actually impose what is called an elimination rider on your coverage, meaning that any health condition that you come to the policy with is permanently excluded from your coverage.

What is also common in this market is what are called teaser rates. So some healthy person might be offered a really low premium rate early on, but as that group of policyholders gets older and sicker, every year their health insurance premiums ratchet up and ratchet up to unsustainable rates. All of that will be prohibited under the Affordable Care Act so that you are guaranteed access to coverage, you are guaranteed no more discrimination because you have a health condition, and insurance companies will not be able to drop you or jack up your rates because you get older and sicker.

Mr. PITTS. The Chair thanks the gentlelady.

The Chair now recognizes the gentlelady from Tennessee, Ms. Blackburn, for 5 minutes for questions.

Mrs. BLACKBURN. Thank you, Mr. Chairman. I want to thank all of you for being here.

I just want to go down the line, Dr. Stark, I will start with you. Yes or no. Would you consider the healthcare.gov rollout to be a success or a failure?

Mr. PITTS. Could you pull your mike up a little bit, Marsha? Thanks.

Mrs. BLACKBURN. Sure.

Mr. STARK. It is a failure.

Mrs. BLACKBURN. Failure.

Ms. DIXON HILL. I think that there are some glitches, but people are——

Mrs. BLACKBURN. Pass or failure?

Ms. DIXON HILL. Success.

Mrs. BLACKBURN. Success. OK.

Ms. CORLETTE. Congresswoman, I am a lawyer and an academic, and I am incapable of providing a one-word answer. I would say that it is a work in progress.

Mrs. BLACKBURN. Get ready. He will ask you for a yes or no. So then you don't know whether, Ms. Corlette, it is a success or a failure?

Ms. CORLETTE. The jury is still out, Congresswoman.

Mrs. BLACKBURN. OK. The jury is still out.

Mr. ROY. Failure.

Mrs. BLACKBURN. Failure.

Mr. ASTRUE. Failure.

Mrs. BLACKBURN. Thank you. I appreciate that. Three are able to answer in one word. I will tell you, according to my constituents in Tennessee, this is an abysmal failure, and it is truly on display a lack of leadership, whether it be from this President, from those that were charged with implementing this, or those who were to deliver a final product. Whether it is the contractors or whatever, and while we don't blame rank and file employees, if you will, what we do is hold responsible those who were supposed to be in charge of this rollout.

It is a failure. I think the American people know that this is a failure, and if we expect, if we say this is a success, then we are saying we don't expect a finished product delivered on time, delivered on budget, with exceptional qualities from those that are spending taxpayer money. Every penny that was spent on this is taxpayer money.

So, no, it is not a success. In my opinion and that of my constituents it is an abysmal failure. It is a disservice to the American people, and it is a shame that the administration would have rolled this out without underpinning it properly.

To my colleagues on the other side of the aisle that say we have no alternative, may I highlight for you, we have been offering alternatives and options for healthcare reform since 2006, whether it is the SGR fix, across State line purchase of health insurance, portability, requiring insurance companies to be responsible, allowing individuals to have healthcare expense and insurance deductibility just like big businesses do, and Ms. Corlette, I have to tell you that you made the statement that no one chooses to be in the individual market unless forced to be there. I take exception to that.

As a small business owner as so many of my constituents are small business owners, they choose to be able to purchase their health insurance, they choose to take control of their healthcare responsibilities. They think personal responsibility is a good thing, and because of the fact that there are millions of Americans who do like to be in the individual health insurance and small business health insurance marketplace, that is why we have seen health savings accounts have such an enormous popularity among the American people. It is an absolute shame that this President said

if you like what you have, you can keep it. And I think the jury is still out as to whether or not he was a part of those conversations as whether or not to decide between the political and the policy ends if that could continue to be said.

But it is incredibly unfortunate that he continued to say that, and I think it is unfortunate that those who were involved in this rollout never whispered to him that he might not want to be saying that. So whether it was his decision or bad staff work, I guess we will find that out later, but we on this side of the aisle do have patient-centered, patient-centered different proposals that we are bringing forward and have been for many years.

And I would be more than happy to submit those for the record, Mr. Chairman, if our colleagues would choose to read them and like to read them and maybe join us in supporting some of these or even supporting the delay of this or support Mr. Upton's bill to allow people to keep their plan if they could like to.

I yield back.

Mr. PITTS. The Chair thanks the gentlelady.

I now recognize the ranking member of the full committee, Mr. Waxman, 5 minutes for questions.

Mr. WAXMAN. Thank you, Mr. Chairman.

I look forward to reading this proposal because we have worked on this issue for a very long time, and the Republicans wouldn't come forward with anything——

Mrs. BLACKBURN. If the gentleman would yield.

Mr. WAXMAN. No, the gentleman will not yield. They didn't come forward with any proposal at all. They even said they want to repeal the Affordable Care Act and replace it. They have never given us a replacement.

Now, I want to ask the panel. If there were a system where nearly 50 million Americans could not get health insurance because they had pre-existing medical conditions and no one wanted to insure them, or they couldn't afford a policy, or they didn't have a policy that covered essential services, or that the drug costs were higher if they were no Medicare, or that an insurance company could increase their premium if they got sick, or that they were forced into personal bankruptcy because their healthcare bills were not covered and they have to pay for it, would you consider that system a success or a failure?

Mr. Astrue?

Mr. ASTRUE. I think——

Mr. WAXMAN. Success or failure?

Mr. ASTRUE. I have never been content with the American Healthcare System and——

Mr. WAXMAN. OK. Mr. Roy, success or failure?

Mr. ROY. It is not accurate to say 57 million people are denied insurance because of pre-existing conditions. It is only about——

Mr. WAXMAN. Excuse me. You are incorrect. Nearly 50 million Americans do not have insurance——

Mr. ROY. Not because of pre-existing conditions.

Mr. WAXMAN [continuing]. Of what the existing system has been. Is that a success or a failure?

Mr. ROY. The existing system is not a success, but it is not because insurance——

Mr. WAXMAN. Excuse me. I don't want to hear your explanations about it. I want a one-word answer.

Mr. ROY. It is because it is too expensive.

Mr. WAXMAN. Ms. Corlette, Mr. Roy couldn't say whether it was a success or failure. He wanted to give me a whole diatribe about it. I want a one-word answer. Is the existing system where nearly 50 million Americans are uninsured a success or a failure?

Ms. CORLETTE. Failure.

Mr. WAXMAN. Reverend Hill?

Ms. DIXON HILL. Failure.

Mr. WAXMAN. Dr. Stark? One word. Success or failure or no opinion?

Mr. STARK. The present system is broken.

Mr. WAXMAN. Thank you very much. The present system is broken, and we try to fix this system. Now, the Affordable Care Act took a lot of these Republican ideas, private insurance companies, personal responsibility be covered, get insurance coverage, that insurance companies couldn't just go out and set these rules and rates that excluded people from coverage rather than spread the costs. That is what we need in an insurance system.

Professor Corlette, tomorrow the House is going to vote on a bill that the Republicans are putting forward. It is misleadingly called Keep Your Health Plan Act. You are an expert in the health insurance market, so I would like to get your perspective on how this is going to affect premiums and the market generally.

Here is what the bill would do. The bill would not require health insurers to allow individuals to keep their healthcare plans. It would not require the health insurers to other those plans. It would allow any health insurance plan for sale in 2013, January, 2013, to be sold all through 2014. Wouldn't require that the plan be there, but it would allow people to buy it if it were there. These plans could remain in the market even if they exclude people based on pre-existing medical conditions, which means they are insuring people who are the least risky. The insurance company could impose these harsh limits on coverage or exclude key benefits like hospitalizations or mental health care.

Just imagine. You buy a policy and then if you need to go the hospital, the plan is not going to cover you. And even though these plans do not meet the Affordable Care Act's consumer protection standards, these plans would not just be available to those who own them, but this bill would allow people to buy into them who didn't have coverage and now could choose that coverage.

Give us some context. Prior to the reform people were always able to keep their insurance from year to year in the individual market, but the market or the plan could change dramatically from year to year. If this legislation became law, what type of impact would this have on the new health insurance marketplaces and on the premiums in 2015?

Ms. CORLETTE. Thank you, Congressman. There is two issues with this bill. First of all, it doesn't solve the problem it purports to solve. It doesn't stop insurance companies from discontinuing policies if they choose to do so.

The second issue is just as you point out, it will result in risk segmentation. It will mean that healthy people get carved out of

the regular marketplace into these old 2013, plans. That will lead to an increase in premiums for 2015, as well as fewer choices for the millions of Americans on the exchange as insurance companies leave that market because it will result in what is called an insurance death spiral or adverse selection against the——

Mr. WAXMAN. The Republicans oppose this law, they fought it every step of the way, they thought that the Court would throw it out, they thought the American people would elect a Republican for President, and we have voted over 40 times to repeal the law, and now they are carrying on again——

Mr. PITTS. The gentleman's time has expired.

Mr. WAXMAN [continuing]. Trying to attack the opportunity to cover Americans in private health insurance plans.

Mr. PITTS. The gentleman's time has expired.

The Chair recognizes the chair emeritus of the full committee, Mr. Barton, 5 minutes for questions.

Mr. BARTON. Thank you, Mr. Chairman.

Let's try before I ask some questions set the record straight a little bit.

Most of what we now call the Affordable Care Act came through this committee. Chairman Waxman was the full committee chairman and Congressman Pallone was the subcommittee chairman. So for better or worse, they deserve the lion's share of the authorship for this law, and at full committee the Republicans did offer an alternative, and I believe on the floor we offered an alternative. I know we offered a motion to recommit. So it is not correct to say that we didn't have an alternative. We did. It wasn't successfully voted on, but it was offered.

As we sit there today the Republican Study Committee has an alternative, and I think in fairly short order Dr. Murphy, Dr. Gingrey, Dr. Cassidy, and Dr. Burgess with the help of the subcommittee chairman, Mr. Pitts, could put a very good alternative together in probably 2 or 3 days.

So if all the Democrats need to move away from the Affordable Care Act is a Republican alternative, I believe we can accomplish that in fairly short order.

Mr. WAXMAN. Will the gentleman yield? Will this plan protect people from being discriminated against because of previous medical conditions?

Mr. BARTON. I think the——

Mr. WAXMAN. Would it stop insurance companies from setting lifetime limits and raising rates? Would it cover people who can't afford to pay for their coverage?

Mr. BARTON. I would say yes, yes, and yes.

Mr. WAXMAN. I want to see that plan, because it wasn't offered when I was chairman.

Mr. BARTON. Well, when you were chairman, you didn't give us a chance to work together on a bipartisan basis, Mr. Chairman, and that is a fact.

Mr. WAXMAN. You know better than that.

Mr. BARTON. No, I don't.

Mr. WAXMAN. You know better than that.

Mr. BARTON. True story. The day the Democrats introduced their bill we were supposed to have a brown bag lunch hosted by myself

and Mr. Waxman. About 2 hours before the lunch, Mr. Waxman called me and said he was going to have to postpone the lunch. When I asked why, he said because we are introducing our bill. Now, that is the truth, Henry, and you know that. That is the truth.

Mr. WAXMAN. That wasn't the end of time for working together. That was putting out our proposal. We——

Mr. BARTON. You did tell me we could cosponsor the bill if we wanted to.

Mr. WAXMAN. I doubt that I said that.

Mr. BARTON. You did. You said you can still cosponsor the bill.

Mr. WAXMAN. You still can support the legislation because it is a good proposal. It is not being implemented well on the——

Mr. BARTON. It is so good that 106,000 people are trying to——

Mr. WAXMAN. And a lot of people are unhappy about losing their insurance, and we got to try to deal with that——

Mr. PITTS. Mr. Barton——

Mr. WAXMAN [continuing]. And not undermine the whole law.

Mr. BARTON. In my State of Texas, according to figures provided to me by Dr. Burgess, who is a very good researcher, less than 3,000 people signed up for the Affordable Care Act. I will give Chairman Waxman credit. California is responsible for a third of the signups. A third. So that is what, 33,000, 34,000 people, but in the next two most popular States, Florida and Texas combined, fewer than 6,500 people have signed up.

Mr. WAXMAN. There will still be time.

Mr. BARTON. Now, if this law is so good, then lots more people than that would be signing up. I have a bill that hasn't had a hearing yet, and hopefully this subcommittee will have a legislative hearing on it, that doesn't repeal, and it doesn't delay, but it does make the Affordable Care Act voluntary the first year. So if it is that good once the Web site gets fixed, and I will stipulate that at some point in time in my lifetime it will be fixed, then let the people choose.

Now, my question in the next 50 seconds, I am going to go to Mr. Roy, over time do you expect that employers will drop their health employees from their healthcare plans because it cost them more to pay the premiums less the tax credit than the penalty would be if they put them in the exchanges and paid the penalty?

Mr. ROY. It depends on the sector and the industry. So, for example, in industries where you have a lot of low-wage workers like restaurants and other franchise businesses, you are likely to see a lot of sorting in that regard. High paid like a law firm, perhaps, will not because the tax exclusion for employer-sponsored coverage is more advantageous.

Mr. BARTON. But in many industries they will?

Mr. ROY. Yes.

Mr. BARTON. At least that is the expectation. And could you tell us, Mr. Waxman cut you off, what percent of the population right now has a pre-existing condition that has not been able to get health insurance because of that condition?

Mr. ROY. Estimates vary, but the most credible estimates put the number at about 1 million people. So the vast majority of the people who are uninsured, it is not because insurers are mean or be-

cause they have pre-existing conditions, it is because health insurance is too expensive, and the fundamental problem with the Affordable Care Act is it makes individually-purchased health insurance even more expensive for most people.

Mr. BARTON. And if you had a system that 85 percent of the people were satisfied with, would you say that system was a success?

Mr. ROY. Not necessarily. Unfortunately——

Mr. BARTON. Wrong answer.

Mr. ROY [continuing]. In the United States the health insurance system is too expensive, healthcare is too expensive, and we could do a lot more to make health insurance more affordable.

Mr. BARTON. All right. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Chair——

Mr. PITTS. The Chair thanks the gentleman.

Mr. WAXMAN [continuing]. Unanimous consent request, if I might be recognized. I would like the gentleman——

Mr. PITTS. Do we have unanimous consent?

Mr. WAXMAN. I would like the gentleman from Texas to be given an additional minute because I took up some of his time.

Mr. BARTON. No. It was productive.

Mr. PITTS. It was very entertaining. Thank you.

The Chair recognizes the distinguished ranking member emeritus, Mr. Dingell, for 5 minutes.

Mr. DINGELL. Mr. Chairman, I thank you for a wonderful hearing, highly political, and we are talking about what we are going to do to repeal or figure out this legislation rather than to perfect it.

I am rather touched that my friends on the other side have developed a newfound concern for the uninsured and those who have been treated poorly by the insurance company. This outrage rings rather hollow to me when for decades we heard nothing from the other side of the aisle about the outstanding and longstanding abuses in the individual market.

Let me give you a couple of little stories here. Let's talk about Judith Gross of Macomb, Michigan. Comes from a 2012, article in Consumer Reports. She received a diagnosis of breast cancer, faced a $30,000 hospital bill. Her policy would only cover 1,000 for outpatient treatment and $2,000 for hospitalizations. Because of this huge expense, she delayed treatment until it was almost too late.

Another story. This is about a family in Colorado. They took their daughter to get an ear tube insertion and found that the procedure used all of the health benefits for 1 year. The individual market was broken before ACA, which is an attempt to put together a system of healthcare which will take care of people like this, and for the first time now consumers have protections against these destructive practices, and we must not forget that when discussing the impacts of the law.

Now, these questions are for you, Professor Corlette, of Georgetown. I hope you give me a yes or no. I just told a few stories about folks who hit lifetime limits on their care prior to passage of ACA. Was this a commonplace prior to the passage of the law? Yes or no?

Ms. CORLETTE. Yes.

Mr. DINGELL. Now, Professor, in fact, your testimony notes that you found that there are 20,000 people who hit these limits annually and 18 million people who had plans with such limits. Is that correct?

Ms. CORLETTE. Yes, sir.

Mr. DINGELL. Now, will these same people benefit from the new consumer protections benefiting lifetime limits on ACA? Yes or no?

Ms. CORLETTE. Yes, sir.

Mr. DINGELL. Now, in your testimony you note that before ACA people with very minor health conditions such as hay fever were denied coverage by insurance companies. Is that correct?

Ms. CORLETTE. It is, sir.

Mr. DINGELL. It also was possible that a woman could be denied care because she was a woman. Right?

Ms. CORLETTE. She could be charged more. Certainly. Yes, sir.

Mr. DINGELL. Now, is it true that some health insurance companies maintained underwriting guidelines that listed more than 400 medical conditions as reasons to permanently deny someone coverage? Yes or no?

Ms. CORLETTE. Yes, sir.

Mr. DINGELL. Now, how many non-elderly Americans have at least one pre-existing condition?

Ms. CORLETTE. It could be as high as 129 million Americans have some form of pre-existing condition, sir.

Mr. DINGELL. Now, before ACA this population was in great jeopardy of not getting access to care because the insurance company couldn't cover them because of their pre-existing condition. Is that correct?

Ms. CORLETTE. Yes, sir.

Mr. DINGELL. And that could do things to people who, for example, had cancer 5 years previously. They could be denied because they had a pre-existing condition. Is that right?

Ms. CORLETTE. That is right, sir.

Mr. DINGELL. Now, is it prohibited for an insurance company to use health status and gender to set premium rates under the ACA? Yes or no?

Ms. CORLETTE. Yes, sir.

Mr. DINGELL. And under ACA only age, tobacco use, geographic location, and family size are used to calculate premiums. Is that correct?

Ms. CORLETTE. It is, sir.

Mr. DINGELL. Now, we have heard a lot about health plans being cancelled in the individual market. Professor, is this a new phenomenon? Yes or no?

Ms. CORLETTE. It is not.

Mr. DINGELL. Been going on a long time. They cancel it, and they can change it every year. Is that right?

Ms. CORLETTE. That is right, sir.

Mr. DINGELL. Now, how many of these cancellations that we are hearing about are caused by the Affordable Care Act, and how much or how many of them are being caused by the whim of the insurance company?

Ms. CORLETTE. Well, that I don't know. We don't know the exact numbers, but certainly in many States insurance companies have

a choice. They can either discontinue a non-compliant policy, or they can bring their policy up to the standard of the Affordable Care Act.

Mr. DINGELL. So in point of fact, oftentimes this is done by the fact that the policy either doesn't meet the standards of Affordable Care Act and is the kind of polices that we discussed earlier where people can't get proper coverage, or it is done because the insurance company just decides they are going to cancel the policy. Is that right?

Mr. PITTS. The gentleman's time has expired.

Mr. DINGELL. You are kind. Could I just get a yes or a no on that, and then I will be delighted to yield the floor.

Ms. CORLETTE. Yes, sir.

Mr. DINGELL. Thank you.

Mr. PITTS. The Chair now recognizes the vice chairman, Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman, and just in the spirit of where we have been this morning I want to also offer a couple of philosophical observations.

Ms. Blackburn from Tennessee made note of the fact that purchasing insurance across State lines was a Republican idea. This is one that has been co-opted by the Obama administration. My understanding is that people on my district staff are now going to be required under the new tenants of the Affordable Care Act to purchase their insurance in the DC Exchange, and for those of you unfamiliar with the geography, there is a State line between Texas and Washington DC, but my employees in district office will be required to purchase across State lines.

Mr. Chairman, I think this would be a very good time for our committee to revisit the concept of purchase of insurance across State lines since the administration clearly has no trouble with that.

Dr. Stark, I am so grateful to see you here today. I just can't tell you, this bill that was signed into law, the Affordable Care Act, was a House bill, but it was a House bill that was drastically changed by the Senate. It was H.R. 3590. When the House worked on it, it was a Housing bill. The House did work on a healthcare bill. It was H.R. 3200, but that has been lost into the myths of time. No one has seen it for years because H.R. 3590 was a product that came over from the Senate, which was vastly different from H.R. 3200, but still, through all of the hearings that our committee had on H.R. 3200, would you care to guess the number of doctors who sat at this witness table and testified to us on H.R. 3200? If your answer were zero, it would be correct.

So the fact that we have you here today to me is a breath of fresh air, and the fact that you are an AOA member, worthy to serve the suffering, a doctor's doctor. I welcome you here today, and I think you are certainly deserving of the high praise. One of the ironic situations is that in Camden, New Jersey, there was a family physician, Jeffrey Brenner, who came and talked to us at the Commonwealth Fund several years ago. I think it was 2010. Dr. Brenner showed a picture of his building, his family practice. It was a stone building that was there in Camden, New Jersey.

Someone asked him if he still had the practice, and he said, no, I had to close it. They asked why, and he said because of Medicaid.

And it is your observations about the difficulties with Medicaid that I think Dr. Brenner was also referring to that day back in 2010, because herein is the problem. You have access to a coverage card but no access to actual care. Did I understand your testimony correctly there?

Mr. STARK. Yes. That is absolutely correct. Yes.

Mr. BURGESS. And I was fortunate enough to get to be at the Supreme Court on the day of the second oral argument, the second day of the oral arguments. I had some problems with the assertions that were there that the reason healthcare costs so much in this country is because people don't buy insurance, that it is these darn free riders. Man, these free riders are just costing us so much money, but Dr. Stark, in your experience the people who are covered under the expanded Medicaid in your State who don't actually have access to a physician because the physician is not taking new Medicaid patients into their practice, where are they going to go when they have right lower quadrant pain at 3:00 on a Saturday morning?

Mr. STARK. Well, they will still use the emergency room, or they will use a clinic. They will not be denied care.

Mr. BURGESS. Well, they probably won't use the clinic at 3:00 in the morning, and we all know how human behavior is. I hope it will get better, so I am not going to do anything about it right now. But we really have done nothing to impact or lower the utilization of some of the high-cost access points in the system by just simply expanding Medicaid. I really wish it were that simple, but it is clearly not as you so eloquently alluded to.

You know, the concept of a high-deductible plan, I don't have a problem with that. I have had a high-deductible plan since 1997, it has been able to be coupled with a health savings account. I guess what bothers me now about the Affordable Care Act is you are going to have a lot of people with high-deductible plans, the actuarial value 60 percent. That is a high-deductible plan. That is 6,000 or $6,500 deductible, and yet there is no possibility of marrying that with a health savings account. If we had been serious about holding down the cost of coverage in this country, we would have brought Governor Mitch Daniels in here to this very witness table, chained him to the table leg until he told us how he was able to reduce costs in his State for State employees about 11 percent over 2 years, and the answer was coupling a high-deductible health plan with a health savings account.

Mr. Roy, you look like you wanted to answer very much when some of the discussion was going on earlier about the pre-existing population. I know you have some thoughts about that. I mean, let's be honest. In the large employer market pre-existing condition problems don't exist, do they?

Mr. ROY. Well, one way we can measure what the true population of people who were uninsurable do to pre-existing conditions is is the pre-existing conditions program in the Affordable Care Act, which only enrolled I believe at the end 200,000 people, and in order to sign up for that program you had to have been uninsured for I believe 6 months, and that uninsurance had to have

been because of a pre-existing condition. Only 200,000 people signed up for that program.

Mr. BURGESS. Well, let me ask this. How many people have signed up since February 1 of this year?

Mr. ROY. I believe it is closed down now. Right?

Mr. BURGESS. That is correct. They are not allowing people to show up because they have mismanaged the problem so poorly that it is not even there to take care of the number one problem they said we had to correct.

Mr. ROY. Right.

Mr. BURGESS. This is what government management will get you. When in your experience has the infusion of vast amounts of Federal dollars resulted in a lower price for anything? I am thinking banking, housing.

Mr. ROY. Never in my experience and I would just add that I do think the pre-existing conditions problem is an important problem, but the idea that there is these tens of millions of Americans who can't get insurance because of pre-existing conditions is absolutely not true, and it is not a contribution to an honest debate about our healthcare system, which does have a lot of flaws to say otherwise.

Mr. BURGESS. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman, Mr. Butterfield, 5 minutes for questions.

Mr. BUTTERFIELD. Thank you very much, Mr. Chairman, and thank the witnesses for your testimony today.

You know, I have heard a lot of complaints today about the enrollment data that we received yesterday, and it is all over the news today, and the President ought to begin talking about it in just a few minutes, but the Republicans are attacking the administration for not releasing enough data, for not releasing it often enough, and of course, for not getting enough people enrolled in coverage.

The arguments are quite strange to me personally, especially given the fact that Republicans really don't want people, in my opinion, to sign up for this program. Why do I say that? I say it because your behavior and your repeal efforts over the last 3 years suggest that you really don't want to exert the energy and the political capital to make this thing work. The administration is releasing enrollment numbers monthly just like they do with Medicare and the CHIP Program and other Federal programs, and that is what they have promised from the very beginning.

Let me tell you what else the administration has promised. The administration has also promised to do what every leader in this country has tried to do over the last 50 years, and that is to fix a seriously flawed system. There is a lot of interest in this obviously, but I don't believe daily or weekly enrollment numbers really make that much of a difference. The Republican legislation to require more reporting is not the product of some newfound interest in making the law work. It is an attempt to place an excessive administrative burden on the department while providing no real benefit to the public.

In terms of the numbers themselves, we knew enrollment would be low in the early days. We knew that. We have had past experiences just like there were in Massachusetts.

And so let me start with you, Ms. Corlette or Dr. Corlette. You studied these issues. Did you expect the majority of people to sign up for coverage at the very beginning of the program, or did you expect things to sort of ramp up over a 6-month period?

Ms. CORLETTE. Absolutely not. In past experience with rollout of other programs like in Massachusetts like with Medicare Part D, people don't enroll right away, and certainly there is no reason to enroll right away when the coverage doesn't start until January 1. So I think we will see a big uptick in mid-December when people need to sign up for January 1, and then we will see another uptick in March when people need to sign up at the end of the open enrollment. But I wouldn't expect to see a lot of enrollment in October regardless of the issues with the Web site.

Mr. BUTTERFIELD. And as I understand it, our research seems to suggest that Massachusetts, the Commonwealth of Massachusetts only signed up .3 percent, three tenths of 1 percent of overall enrollees for private coverage in the first month. Thus far, 1.5 percent of the ACA's target enrollment have signed up. Some of those in my district. Not enough but they are signing up.

It is not fast enough, but I am hopeful that we are on the right track, and so I want to thank you, all of you, for your testimony today.

I yield back.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman. I am going to try to get back to Medicaid, but before Professor Corlette, you have stirred a lot of interest and just because of your opposition to the Upton bill and I hope you are as much opposed when the President in a few minutes says he is going to do an administrative fix to do what you so adamantly claimed is a failed policy.

I would also just to put on record that 200,000 people who have coverage and have pre-existing conditions have lost it under catastrophic plans that have been dropped throughout States because they don't meet the minimum requirements under this law.

And the administration's promise, if you like your healthcare plan, you can keep it. That is what he said. And that was a lie. It was not correct. It was deceptive to the American people, and you know, we are all receiving the letters of denied plans, and even from hardened Democrats. I got one here from a strong Democratic family from San Francisco. They are cradle Democrats, and they say from all the sob stories I have heard and read ours is the most extreme. They have lost their plan. So this is not Republican, Democrat. This is affecting all our constituents, and it is very frustrating.

The other thing I want to raise, Ms. Corlette, do you know that when you go on the Obamacare Web site that, I was interested in your comment about teaser rates. Do you know who is the biggest abuser of teaser rates right now? Healthcare.gov. Did you know

that? And you know why? That is a question. Professor Corlette, do you know why?

Ms. CORLETTE. I wasn't sure if you were being rhetorical or not.

Mr. SHIMKUS. No. I am asking that question now because it is very important, because I have raised this numerous times in hearings.

Ms. CORLETTE. When I spoke about teaser rates, what I was talking about is in the individual market——

Mr. SHIMKUS. OK. Let me just reclaim my time.

Ms. CORLETTE [continuing]. For healthy individuals who are able to get coverage.

Mr. SHIMKUS. Let me reclaim my time. If you would define teaser rates as offering a lower rate than what at the end sold, if you knew that the healthcare Web site will quote a 50-year-old the price of a 27-year-old, wouldn't you consider that a teaser rate?

Ms. CORLETTE. No. It is a different situation.

Mr. SHIMKUS. OK. OK. A lawyer. You can say yes or no——

Ms. CORLETTE. I mean, you are talking about, I think you are talking about——

Mr. SHIMKUS [continuing]. When you get the questions from the Democrat side, but you can't say yes or no when you get the questions——

Ms. CORLETTE. You are talking about——

Mr. SHIMKUS. Likewise if you are——

Ms. CORLETTE [continuing]. A glitch.

Mr. SHIMKUS [continuing]. A 62-year-old, and you go up on the Web site to get the price, and they quote you the price of a 50-year-old, wouldn't you consider that a teaser rate?

Ms. CORLETTE. I would call that a mistake.

Mr. SHIMKUS. And I would call the healthcare law a mistake. So we are even on that one.

Dr. Stark, my big issue is this Medicaid concern. I visited hospitals, I have talked to counselors, I have talked to navigators. In one hospital that has the contract, just last week they signed up 48 people. I asked them, well, how many of those Medicaid people are new enrollees based upon the new standard, and I was in the Board room so I had a lot of big wigs there, and the one said, well, I think all of them, and I said, I bet it is not. So the person who was actually managering said, 24 percent or as we term out of the woodwork, 24 were new enrollees.

So Illinois is a 50/50 State. That is just one small section. How is that going to disrupt Medicaid delivery and the cost to the State of Illinois and the Medicaid System if this 50 percent enrollment number is true across the country, which I think it is going to be.

Mr. STARK. Yes. That is a real good question. The answer is the burden on State taxpayers is definitely going to go up because of the existing Medicaid patients newly enrolled now because of the public relations——

Mr. SHIMKUS. Which wasn't planned for because when the bill was proposed, the promise to States was the new enrollees you would get 100 percent for the first 3 years and then it goes down to 90 percent, but no one really believed that these out-of-the-woodwork folks would be so high that they are going to cause a huge financial burden on not just our State of Illinois but in every State

that has Medicaid, which is a reason why maybe some of the Republican governors understood the additional financial burden. Don't you think?

Mr. STARK. Yes, absolutely. Plus there is an additional build in the law, an additional 10 percent the State taxpayer is going to have to pay ultimately. Washington is a 42–58 percent State, so Washington State taxpayers are going to be on the hook for 42 percent in these woodworker, welcome mat patients. Yes.

Mr. SHIMKUS. Tell Governor Inslee we all said hi. He is a good friend of ours.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Texas, Mr. Green, for 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman.

Ms. Corlette, thank you for coming to speak with us today about your research on the failures of the individual insurance market and the impact of the Affordable Care Act. I represent a very urban district in Texas, and we not only have the highest number of uninsured in the country percentage wise but in our district we have some of the highest in the country per Congressional district of uninsured people who work.

Like many of my colleagues I am frustrated over the troubled rollout of the Federal Health Exchanges. I want to see every action taken to fix the Web site as soon as possible so we can deliver on the promise of providing millions of uninsured and underinsured Americans access to the affordable quality insurance.

I think it is important to remember why the ACA came to be and to reflect on the systemic problems of the individual insurance market that left 48 million Americans uninsured, featuring rampant adverse selection and rising premiums and families and individuals with coverage that provided low value and little security from bankruptcy if they got sick.

I use the example I had a constituent who worked for a retail operation that went to the doctor and discovered she had a tumor. Her policy that was issued through her employer had a cap of $25,000. That surgery at Memorial Hermann Hospital, a great facility in Houston, was over 250,000. That employer was ashamed enough to help to pay for that instead of having either the taxpayers or the non-profit side of that hospital have to pay for it.

Can you remind me of all the failures of the individual health insurance market and the important reforms included in the ACA to address to these? Why was the individual market so broken prior to the passage of the Affordable Care Act?

Ms. CORLETTE. Well, I think one thing that clearly happened to your constituent and happened to many, many Americans in this market is that this coverage is inadequate to meet people's needs when they have healthcare issues just like any of us would. So in this situation you have, as you point out, health plans that prior to the ACA had really low annual limits, high, high deductibles, often excluded things like prescription drugs, maternity, mental health services, coverage that was like an umbrella full of holes, would not be there when the person actually needed to use it.

Mr. GREEN. The joke in some of my community is that we pay insurance premiums, but when we need it, it is not there, and that was the image.

And I only have 5 minutes, so I am going to ask. In our healthcare system people receive emergency medical treatment for life-threatening situations in emergency rooms regardless of whether they have insurance. What is the overall impact on the cost of health insurance premiums and the healthcare system in general having these people without coverage using the emergency room?

Ms. CORLETTE. I believe from the estimates that I have seen is we all pay an additional $1,000 on our premiums to make up for this free care that people get in emergency rooms, but I am not exactly sure of the number, but it is a significant surcharge on all of our premiums that we pay to cover this kind of uncompensated care.

Mr. GREEN. Well, one of the concerns I have is part of the Affordable Care Act was the expansion of Medicaid to a lot of constituents that I have who are working poor. They work, but they don't have enough, they can't afford it, their employer doesn't provide it, and yet States like my home State of Texas did not expand Medicaid. Hopefully we will get a new governor and make that decision differently because that impacts all my hospital systems. Every one of them would prefer the expansion of Medicare, even my great partnership, our Chamber of Commerce lobbied in Austin to have that.

So we understand the spreading of the risk and having people have an instrument of insurance whether it be Medicaid or the Affordable Care Act going in.

The principle insurance, any type of insurance is to provide real financial protection to individuals and families through risk pooling. There have been reports of people currently in the individual market receiving letters about plan cancellations. Health insurance touches everyone's lives deeply and personally. Can you provide an explanation on why these letters are sent and their connection to the Affordable Care Act?

Ms. CORLETTE. Sure. I think there are three options that people are often given if a health insurance company has decided to discontinue a policy. Many policyholders are being encouraged to early renew their plans, and typically that would mean that they would just move up the anniversary date of coverage so that it would renew in 2013, so they would get up to an extra year on their plans.

The other option that people are often given is to purchase an ACA compliant plan through the same company or to research their new coverage options on the exchanges. Close to 50 percent of this individuals will be eligible for premium tax credits on the exchanges, and so millions, millions will get a far better deal on the exchanges than they can currently find in the individual market.

Mr. GREEN. Thank you, Mr. Chairman, for your——

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. MURPHY. Thank you. Abraham Lincoln once was asked how many legs does a dog have if you call a tail a leg, and his response

was four because calling a tail a leg doesn't make it a leg. Or said another way, George Orwell once said, "In a time of universal deceit, telling the truth is a revolutionary act." So I am going to ask you folks to respond to me truthfully.

As we are here, the President is announcing that he is allowing the States to make decisions to maintain the health insurance plans people currently have. He is going to leave that up to the governors. Quickly going down, would each of you recommend that the governors from your State go ahead and allow people to keep their plan if they like it?

Mr. Astrue, start with you. That is a yes or no. Should the governor say people can keep their plan if they like it?

Mr. ASTRUE. Yes.

Mr. MURPHY. Mr. Roy?

Mr. ROY. Hopefully yes. I would have to know the details of what he is planning to——

Mr. MURPHY. Ms. Corlette?

Ms. CORLETTE. Similarly I would have to see the details.

Mr. MURPHY. Reverend?

Ms. DIXON HILL. I agree.

Mr. MURPHY. With what the President is doing? What that the President is doing? You agree with what the President is saying should happen? The States should decide?

Dr. Stark?

Mr. STARK. Yes. I would say yes.

Mr. MURPHY. You agree with the President, allowing the States to decide?

Mr. STARK. That is a step in the right direction.

Mr. MURPHY. All right. OK. There is a couple of other things. Just quickly.

Does this bill make it illegal to deny coverage to people based upon pre-existing conditions? The Affordable Care Act.

Mr. ASTRUE. The current bill. Yes or no. Does it say you can't deny people coverage? You haven't read it. OK.

Mr. Roy? It is simple. Mr. Roy?

Mr. ROY. Yes.

Mr. MURPHY. OK. Ms. Corlette, does it say you can't deny people coverage based on pre-existing conditions?

Ms. CORLETTE. It does.

Mr. MURPHY. OK.

Reverend?

Ms. DIXON HILL. It does.

Mr. MURPHY. Dr. Stark?

Mr. STARK. Yes.

Mr. MURPHY. OK. That is good. That is reality.

Now, another reality is some parts of this bill helps people but other parts of the bill still leaves many people with unaffordable insurance. I have got a letter here, a 63-year-old said the Affordable Care Act plan is 37 percent more expensive than what I am paying now. It is $19,200 a year under this bill. Another person, a single mom writes me that she is being offered a plan that she can't afford anymore. Another person says their bill is going up from $200 and some a month to $800 some a month from $200 a month.

So isn't it true that while this bill is helping to make it affordable for some people it is also making it unaffordable for some people?

Mr. Astrue, is that true?

Mr. ASTRUE. Yes.

Mr. MURPHY. Mr. Roy?

Mr. ROY. Absolutely.

Mr. MURPHY. Ms. Corlette? You have got to be able to answer that one. You must have some compassion to say that this is unaffordable for some people. Forget being a lawyer. Be a mom, be a person. It is unaffordable for some people now. Yes or no?

Ms. CORLETTE. If you will give me the opportunity to answer the question, I would say that——

Mr. MURPHY. Yes or no?

Ms. CORLETTE [continuing]. Some people will pay more——

Mr. MURPHY. Thank you.

Ms. CORLETTE [continuing]. Than they have been paying.

Mr. MURPHY. Is it going to be unaffordable for some people based upon those numbers?

Ms. CORLETTE. Do I think that the——

Mr. MURPHY. This is a simple question.

Ms. CORLETTE [continuing]. Tax credits——

Mr. MURPHY. Please. I have asked you to tell the truth here.

Ms. CORLETTE. Yes.

Mr. MURPHY. Thank you.

Reverend Hill, is it going to be unaffordable for some people based upon—for some people, not for all, but for some people now?

Ms. DIXON HILL. For some people.

Mr. MURPHY. Thank you.

Dr. Stark?

Mr. STARK. Yes.

Mr. MURPHY. All right. Here are some other quick true and false things. It has been said that if you like your plan, you can keep it. Was that the truth?

Mr. Astrue?

Mr. ASTRUE. No.

Mr. MURPHY. Mr. Roy, was that the truth?

Mr. ROY. No, and it was never designed to be that way.

Mr. MURPHY. Ms. Corlette?

Ms. CORLETTE. In order to fix the health insurance market, you have to change the health insurance market.

Mr. MURPHY. I didn't ask you that. I asked you if that statement was true or false. When you tell people you like your plan, you can keep it. I don't need you to dance around this. I don't need a lawyer. I need honest answers. I ask you to do that for the sake of the American people. Was that true or false when people were told, if you like your healthcare plan, you can keep it?

VOICE. Mr. Chairman, what is——

Mr. MURPHY. I am asking a question.

Mr. PITTS. The gentleman from Pennsylvania controls the time.

Mr. MURPHY. Is it true or not?

Ms. CORLETTE. And I have to answer you that I cannot speak for the President and what he said. I can't——

Mr. MURPHY. I asked——

Ms. CORLETTE [continuing]. Tell you that——

Mr. MURPHY. Ms. Hill, Reverend Hill, is it true or not when people were told if they like their healthcare, they can keep it? Was that a true statement?

Ms. CORLETTE. That is what the President said but——

Mr. MURPHY. I didn't—you are done.

Reverend Hill, is that a true statement or not?

Ms. DIXON HILL. He made the statement.

Mr. MURPHY. Is it true or not?

Ms. DIXON HILL. I can only say he made the statement.

Mr. MURPHY. Reverend.

Ms. DIXON HILL. He made the statement.

Mr. MURPHY. I didn't ask you if he made the statement. I am asking you if it is a true statement.

VOICE. Mr. Chairman, they can't tell what the President said——

Mr. MURPHY. I control the time. I am asking if it is true. I didn't say the President. You said the President. Is it true or not if someone is told that they like their plan——

VOICE. Badgering the witness.

VOICE. It is really not fair to ask them——

Ms. DIXON HILL. He made the statement. That is all I can say. I don't know what was in his mind.

Mr. MURPHY. I didn't say the President said that. Lots of people said it.

Dr. Stark, is that a true statement, to say if you like your plan, you can keep it?

Mr. STARK. It was absolutely false, and he either knew it was false or he is terribly naíve.

Mr. MURPHY. Thank you very much.

I go back to the statement, "At a time of universal deceit, telling the truth is a revolutionary act." For those of you who tell the truth, I thank you.

Yield back.

Mr. PITTS. The gentleman's time has expired.

The Chair now recognizes the gentlelady from Illinois, Ms. Schakowsky, 5 minutes for questions, please.

Ms. SCHAKOWSKY. Well, it will be interesting to see now that the President has made a change that will allow people to keep the policies that they have, what the other side will come up with as yet another excuse, and let's face it. All of the programs that we have rolled out, the big ones, Medicare Part D and Medicare and Social Security, have required Congress to help work, and I am sure you know that as an actuary that we have had to make changes over time in these programs. We don't have a partner to do that, so the President is doing his best now to comply.

But I think that there has not been enough conversation about some of the worse abuses that have been in the private market. We have done some of that today to ensure that everyone has access to affordable health insurance. So some people are going to be offered, if the insurance companies want to continue to offer them the plans they still have. Let's remember, one of the big reasons that people can't keep the policies they have is because the insurance companies change them every year, and so they aren't available.

But, anyway, I went to ehealthinsurance.com, a Web site that allows people to shop for insurance, and I looked at plans that were available in Cook County, Illinois. That includes my district, and let me just tell you one plan that I found. The copay select value 10,000 plan offered by United Health One. It has a $10,000 deductible and requires 30 percent coinsurance after deductible has been met, and this is the basic plan before any underwriting would take place on pre-existing conditions. The plan does allow doctors' visits with a $35 copayment before the deductible is met, but only four visits. Afterward the customer has to meet the $10,000 deductible before the insurance company will pay anymore for the doctor visits. At that point the consumer would pay 30 percent coinsurance per visit, and then the plan has an out-of-pocket max of $10,000, but this cap doesn't include the $10,000 deductible the consumer may pay.

So in addition to the consumers potentially facing $20,000 in medical bills each year for what is covered in the plan, let's look at what is not covered. Brand-name prescription drugs, maternity services, mental health services, substance abuse services. So I want to ask Ms. Corlette, is this good for our country that ultimately maybe after a year it be allowed on the market?

Ms. CORLETTE. I wouldn't even call that health insurance. It doesn't offer the basic things that health insurance should provide, which is access to care and financial protection when you get sick. So that coverage will no longer be allowable and rightfully so.

Mr. ASTRUE. If I may just take 10 seconds.

Ms. SCHAKOWSKY. OK.

Mr. ASTRUE. And attempt maybe full-heartedly to get some consensus on this subcommittee. You have done something important, which is you have tried to shop, and that is a feature that is not built into healthcare.gov now, and so one thing that ought to bring us together as Republicans and Democrats is to work with the agency to try to let people—I have tried to do it, you know. I haven't worked full time since I left the government, I am an interim employment, and I have tried to shop——

Ms. SCHAKOWSKY. Very frustrating.

Mr. ASTRUE. It is very frustrating.

Ms. SCHAKOWSKY. Totally.

Mr. ASTRUE. So if nothing else comes out of this hearing maybe all of you can work together on a bipartisan way to stress to HHS it is very important to change the design system that prevents Americans from doing what you just very importantly did on——

Ms. SCHAKOWSKY. You know, you are absolutely right. I mean, those of us who are supporters of the legislation would like to be able to say to people, look, I just got this letter and to say, wait a minute. Calm down. Just go to the Web site and see if you can find a better deal for yourself. Of course, that is so very, very frustrating. All of us feel that. No one is ignoring that as an unacceptable flaw in the rollout. You know, for those of us who support it, maybe even more frustrating because we want to be able to show people that this is good.

I want to say one other thing. Medicaid, are you saying doggone it, those people who are eligible for Medicaid have always been eligible for Medicaid, now it is a big problem because they are coming

out of the woodwork to sign up? God love them for coming out of the woodwork to get the kind of healthcare that they are eligible for. This is a good thing, and I yield back.

Mr. BURGESS [presiding]. The gentlelady's time has expired.

The Chair recognizes the gentleman from Georgia, Dr. Gingrey, 5 minutes for questions, please.

Mr. GINGREY. Mr. Chairman, thank you very much.

Just an hour ago I accompanied one of my staff employees to the Member Services Office of Finance to check on what it is going to cost her when she goes into this health link, DC Health Link Exchange. She currently under the Federal Employee Health Benefit Plan pays $90 a month as a single individual. Her premium per month is going up to $270. She pays no deductible currently under FEHB. Her deductible goes up to $1,000. So she is paying about $3,160 a year more.

This is a 200 percent increase in what she currently is paying. Members are having 200, 300 percent increase in what they are paying, and this is with the, really the unfair subsidy that taxpayer, we the taxpayer subsidy that the President convinced the Office of Personnel Management to grant to the members and their employees even if their income doesn't meet the standards to get a subsidy. If they weren't getting that subsidy, my employee, this young lady, would probably be paying 500 percent more, and it is even worse in the individual market when you talk to individuals in my State of Georgia and States of members on both sides of the aisle. They can't deny it. There is no question about it. The President has consistently said that what is now reality would never happen, that if you like your health plan, you can keep it period. That is also part of the quote, the period, and this has not proven to be true for the millions of Americans who have seen their plans canceled due to Obamacare and provider networks that have been narrowed to prevent even more sticker shock.

Look, this was all about, should have been about maybe in the individual market in particular reform of the health insurance market. I mean, that can be done. That could easily have been done to allow young people up to the age of 26 to stay on their parent's health insurance policy, to make sure that children with preexisting conditions could get health insurance, to have high-risk pools within the States, which many States already have.

But so what we did is spend about $2 trillion creating a whole new entitled program which is basically a one-size-fits-all, even though some 55-year-old bachelor now has infertility and maternity coverage he is paying for but I don't think he is going to ever need.

But now I do believe this, and I am going to get to my question, and it is going to be for Mr. Roy. I believe that there is another population that will soon feel the effects, what a misnomer. It should be the Unaffordable Care Act, but this population has been underreported. We know that $716 billion was taken out of the Medicare Program, Mr. Roy. One hundred and fifty-six billion from Medicare Advantage and really to create this whole new entitled program. In the current individual market we have seen individuals switch doctors as provider networks have narrowed, reimbursements have fallen within exchange plans. With the $415 billion cut in Medicare updates to fee-for-service payment rights to

providers, to hospitals, what is the likelihood that seniors may lose access to their doctors and be forced to try to find new ones?

Mr. ROY. This is an emerging problem, and I know this committee has had debates about whether or not access to physicians among Medicare enrollees is a problem. From what I see and from the data I see broadly, not just Med Pack data but across the spectrum, it is an increasing problem, particularly for seniors who move to a new location. So a grandmother in New York moves to North Carolina——

Mr. GINGREY. Let me switch real quickly to the other follow up on that is in regard to Medicare Advantage, $156 billion that we are talking about of Medicare Advantage. Of the 47 million people that have Medicare, 25 percent of them choose Medicare Advantage. What is going to happen to them?

Mr. ROY. Richard Foster, the former Chief Actuary of CMS, projected that 50 percent of Medicare Advantage enrollees would revert back to the traditional fee-for-service program because of the changes to the Medicare Advantage Program.

Mr. GINGREY. Well, Mr. Chairman, the administration implies that the disruptions that Obamacare has caused to individuals will stay relegated to those buying the insurance individually. Our seniors need to be warned that this disorder will soon come to them if it has not already, and this law is not just a disaster for individuals, it is a disaster for our Healthcare System and will soon, soon be a disaster for our seniors. No amount of IT resources will fix the underlying problems. As Dr. Burgess said, that will be fixed eventually. This is the end of the beginning of the problem, the tip of the iceberg. No amount of IT resources will fix the underlying problem. This bill is truly a train wreck for Americans and particularly for our seniors, and I yield back.

Mr. PITTS. The gentleman's time has expired.

The Chair recognizes the gentleman from Louisiana, Dr. Cassidy, 5 minutes for questions, please.

Mr. CASSIDY. Thank you, Mr. Chairman.

Ms. Corlette, I gather that you oppose the preservation of the small group market?

Ms. CORLETTE. No, sir.

Mr. CASSIDY. So the folks getting cancellations, the rules that were written effectively mean what 80 percent of those folks would lose—I am sorry. Not small group. I am sorry. The individual market. Individual market.

Ms. CORLETTE. Individuals whose policies are being discontinued at the end of this year, many of them are getting three options. The first——

Mr. CASSIDY. But just simply I gather that you would think it is a back idea, the Upton bill, for example, which allows people to continue in the individual market should they choose.

Ms. CORLETTE. I think the Upton bill has two problems. One, it doesn't——

Mr. CASSIDY. Wait. I am sorry. I have limited time. I am just trying to rephrase and set a context for my next question. Would you agree that that——

Ms. CORLETTE. I believe there are a lot of inadequate, unaffordable policies on the individual market today that need to meet basic minimum standards to be considered health insurance.

Mr. CASSIDY. So the President reportedly is about to announce that he is going to either require whatever, insurance companies to continue to sell on the individual market. Now, I gather that you think that is probably a bad decision. The policies currently being canceled reportedly will no longer have to be canceled.

Ms. CORLETTE. Honestly, sir, I would have to look at the President's proposal to be able to speak——

Mr. CASSIDY. But in concept?

Ms. CORLETTE. I would have to look at the details.

Mr. CASSIDY. I find you are willing to conjecture on things which support your position but not on things which don't.

Would you concede that the young people not signing up for the exchanges is a potential problem?

Ms. CORLETTE. If they don't sign up by March 31, it is a big problem, but they do have until March 31 to sign up for coverage.

Mr. CASSIDY. And it is arguable whether or not young people will pay substantially more than the going rate to purchase something which they currently don't purchase. That is my perspective, but that said, if they don't, you spoke earlier of an actuarial death spiral. Is it fair to say that if the young people don't sign up, that the business plan is such that quite likely the exchanges will enter somewhat of that actuarial death spiral?

Ms. CORLETTE. It is critically important for young and healthy people to sign up.

Mr. CASSIDY. And if they do not?

Ms. CORLETTE. There will be premium increases over time. Yes, sir.

Mr. CASSIDY. And if it is assumed, it was once said that for every 10 percent increase in premiums you lose roughly 1.4 percent of subscribers but, of course, that is a compounding effect. That increases premiums further and then more people unsubscribe.

Ms. CORLETTE. That is why it is called the death spiral, sir.

Mr. CASSIDY. So, now, Mr. Roy, Dr. Roy.

Mr. ROY. Yes.

Mr. CASSIDY. You have done stuff looking at apples and apples comparison, ehealth versus the exchanges. I think young men in San Francisco are going to pay 40 percent more on the exchanges. What is your opinion as regards how likely these young men are to sign up for these exchanges?

Mr. ROY. It depends on how much the mandate convinces them to sign up versus the rate increases, but experience and our experience in Massachusetts and experience broadly suggests that the rate increases are far higher relative to the fine that people will pay under the individual mandate, particularly in the first year, and therefore, we are likely to see adverse selection. In fact, we know from anecdotal reports, not from HHS by the way, we know from reports from State governments that the average age of the enrollee on many of the State exchanges is higher than what people were hoping for or projecting.

Mr. CASSIDY. So it looks as if we are getting those folks basically over 50 or with chronic medical conditions signing up, but we are not getting the young people.

Mr. ROY. That appears to be the case, and the Web site problems exacerbate that because the people who are most desperate for coverage are the ones who are most willing to put up with all the hassles of signing up.

Mr. CASSIDY. So our concern as Americans should be because I agree with Mr. Astrue, we need to look at this as Americans, not as one party or the other, we have scorched, earthed the individual market, but we set up a system where young people don't appear to be signing up, only the older, and then we will end up with the actuarial death spiral so that even those who are older will end up paying higher premiums than they otherwise would have paid.

Mr. ROY. It will depend on whether they are eligible for subsidy. So if you are eligible for subsidies, the subsidy level will increase to cushion some of that, but if you are not eligible for subsidies, you will pay the full freight, the underlying——

Mr. CASSIDY. This coverage is only a percent, so even if it is a percent, the percent that you are left in pocket will continue to rise.

Mr. ROY. That is correct.

Mr. CASSIDY. And I have found as a doctor who still treats the uninsured in a hospital for the uninsured, a clinic for the uninsured now, I have found that those who are poor very sensitive to price increases. Don't we know that from Indiana or Wisconsin that even minor increases in Medicaid copays cause a dramatic drop off in people participating?

Mr. ROY. We also know from the market research that insurers have done for the exchange that they have publicly disclosed in their earnings calls that the participants in the exchange are extremely price sensitive, and that is why these plans have narrow networks because insurers, carriers believe that narrow networks are preferable to higher premiums in a competitive market.

Mr. CASSIDY. Thank you all. I yield back.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Kentucky, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman.

My State of Kentucky has been listed as one of the States being supposedly successful with the exchange, but I will tell you in the 1990s our general assembly completely destroyed our individual insurance market. So I understand New York is a State that has also been listed as being successful with this, and I will tell you their general assembly destroyed their individual insurance market. So I think California, which I am not that familiar with, but it appears that other States are subsidized States that destroyed their individual insurance market. That seems to be what is happening.

But having said that, Ms. Corlette, you said if you are going to fix the market, you have to change it. So people are going to be disrupted. You acknowledge that people are going to be disrupted when the healthcare bill—or now. They are now being disrupted because of the impact that they have.

Now, a lot of people are saying insurance companies cancel plans every year. That is true but they usually offer similar plans. Plans, we can't be mistaken, plans are being cancelled because they don't meet the essential minimum benefits of the Healthcare Law, so people are being disrupted that way. Correct?

Ms. CORLETTE. Yes. There is going to be some disruption as we move to a more fair system that lets people who historically have been barred from accessing insurance to allow them to access insurance.

Mr. GUTHRIE. But if you don't disrupt people and put them through the exchanges is what the Upton bill, that is your criticism of it, and you said it creates a death spiral for the exchanges, the Upton bill if passed would create a death spiral for the exchanges.

Ms. CORLETTE. That is one of the biggest problems with the Upton bill, and Mr. Congressman, I would like to show you, this is a report on Kentucky's insurance reforms from the 1990s, and it is really instructive. I think everybody on the committee should read it, but what it says is what happened in Kentucky is that they created, they allowed a set of insurance products to be sold that operated on a different set of rules than the modified community rating——

Mr. GUTHRIE. But not in the individual market. That is——

Ms. CORLETTE. Right, but what happened was insurers left that——

Mr. GUTHRIE. They left the market.

Ms. CORLETTE [continuing]. Left the reformed market in droves, premiums went through the roof. It is Exhibit A of why we need a holistic approach.

Mr. GUTHRIE. But they weren't offering alternatives like letting you keep it if you have it.

Ms. CORLETTE. They were offering——

Mr. GUTHRIE. They left the market because they couldn't compete in all the——

Ms. CORLETTE. They all shifted to association product. So——

Mr. GUTHRIE. People were trying to buy everything they could because it didn't affect employers because most of them were ARESA, so individual, small business, individual buyers, farmers were completely priced out of the insurance market. We repeal those, but we destroyed the insurance market, and they didn't come back. So this, I mean, this is real serious stuff what—not that it is going to be disrupted. We don't know. When you destroy an insurance market, we could not get it back in Kentucky, and but the thing there was a farmer, and I ran in 1988, on this issue because that was the issue for everybody. Who came to me, I remember, and he said he spent about $1,000 a month because he had to buy on the individual insurance market with 33 mandates. So you say, I think you quoted, some of these plans are not health insurance.

Well, somebody in Frankfurt decided that this farmer needed to have 33 mandates in this policy, paying $1,000 a month. He came to me, and he said, if I could just buy catastrophic, so if I had my wife or myself and the two kids have to go to the hospital, we don't lose the farm, I would love to be able to buy that, but I was paying $1,000 a month. I would rather pay a few hundred dollars when

we have to go to the doctor to get tests for whatever out of pocket, and I am money ahead if I do that. That is a rational buyer of health insurance, isn't it? So you are saying that, you would say that is not health insurance, but having a catastrophic policy and paying out of pocket, particularly if you could do health savings accounts with that first dollar coverage, it is a rational way to buy health insurance. His price went up because he was subsidizing other people in the market and his family was fairly healthy, and so this is what is happening. This appears today, so you say the Upton bill would create a death spiral. If there is any similar proposal, whether the President's or not, that allows people to stay in these current policies that are not health insurance, would that also create a death spiral?

Ms. CORLETTE. I can't speak to the President's proposal.

Mr. GUTHRIE. Well, just any proposal that allows——

Ms. CORLETTE. I am really sorry.

Mr. GUTHRIE [continuing]. People to stay—well you say the Upton——

Ms. CORLETTE. I haven't had a chance to look at it.

Mr. GUTHRIE [continuing]. Bill would create it. If any——

Ms. CORLETTE. Essentially what the Upton bill allows is a set of products to be continually—it is not just people being able to keep their policies.

Mr. GUTHRIE. Right.

Ms. CORLETTE. These insurers will be allowed to enroll new customers. If you allow a set of products to be sold on the marketplace that operate by a different set of rules as Kentucky learned in the mid '90s, you will result in adverse selection. There will be adverse selection against the exchanges, and over time premiums will go up in the exchanges, and there will be fewer insurance options for people to choose from.

Mr. GUTHRIE. But then you have people like my farmer who is priced out of the market because they are mandated to make coverages that they don't cover. So we are really using him and his family to subsidize other families.

Ms. CORLETTE. Well, I mean, all of us——

Mr. GUTHRIE. Make sure you are using young healthy to subsidize.

Ms. CORLETTE [continuing]. In employer-based coverage are in a risk pool. Healthy employees subsidize sicker employees. Younger employees subsidize older employees. What the Affordable Care Act attempts to do is bring that same employer-based risk pool and concept to the individual market. But if you allow this segmentation——

Mr. GUTHRIE. But most of the individuals aren't getting employer subsidies to participate now. They are just being priced out of the market.

Ms. CORLETTE. Well, they are getting advanced payments of premium tax credits up to 400 percent of poverty to help——

Mr. GUTHRIE. Yes. It depends on——

Ms. CORLETTE. Correct.

Mr. GUTHRIE. I yield back.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Virginia, Mr. Griffith, for 5 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman.

Dr. Stark, let me ask you a question. A problem has come to my attention in Virginia, which is all the way across the country from you, and it may not be the same in the State of Washington, but we have a dilemma because in order to be eligible for Medicaid you have to have limited assets. It used to be $2,000. That may have gone up in the last year or two, but it used to be $2,000 were all you could have in assets in order to be eligible for Medicaid.

So a situation has come to my attention where a lady has assets. She generates $9,000 a year from those assets. She is not yet old enough, she is a widow, but she is not old enough yet apparently to be in Medicare, and when she goes on the Web site, she is not offered a supplement in Obamacare because she would theoretically based on her income level be eligible for Medicaid. But because she has assets, that is where her small income comes from, she happens to be caring also for apparently a disabled child, she is not eligible for a supplement, and with $9,000 a year in income she cannot afford health insurance.

Is that problem nationwide, or is that just a Virginia-specific problem?

Mr. STARK. I think potentially that would be a nationwide problem. It is the way the system is set up.

Mr. GRIFFITH. So it is going to apply in any State depending on what the number is. If you have assets, you are going to have to sell your assets in order to qualify for Medicaid, and you won't be able to buy health insurance.

Mr. STARK. Potentially I would say. Yes.

Mr. GRIFFITH. It is interesting because this lady in speaking to a friend of mine said, I thought Obamacare was supposed to help people like me, and apparently it is not helping her because she is not going to be able to get any assistance whatsoever, and in some cases I understand the asset may even be the home that they are living in if it is a single person living in that home where you don't have another person who may have ownership in the house. Is that also your understanding?

Mr. STARK. Yes. An asset is an asset. Yes.

Mr. GRIFFITH. So in theory they can either be uninsured, which is where they may have been anyway, but in theory they could either be uninsured or homeless. Isn't that correct?

Mr. STARK. That is I guess by your definition, yes. The way you are putting this.

Mr. GRIFFITH. Yes.

Mr. STARK. Yes.

Mr. GRIFFITH. It is kind of a tough situation.

Mr. Roy, would you like to comment on that? Do you have any different perspective?

Mr. ROY. The biggest problem, there are a number of problems with the way the mandate is enforced, but I would say that in general people can reorganize their income or sometimes misreport their income in order to avoid the mandate and maximize the subsidies.

Mr. GRIFFITH. Now, we don't want to encourage anybody to misreport their income because that gets awful close to fraud, but how would you manage that asset?

Mr. ROY. Well, if your income is below that required to file a tax return, the mandate doesn't apply to you, for example.

Mr. GRIFFITH. Oh, so she wouldn't have to pay the fine for being poor and having an asset, but she still wouldn't have insurance.

Mr. ROY. That is correct.

Mr. GRIFFITH. OK. So that is how she would manage her assets.

Mr. ROY. That could be one, "option."

Mr. GRIFFITH. One option. As long as she didn't have to file any tax return with the IRS.

Mr. ROY. Right, because the IRS otherwise can't verify her income, and the law actually explicitly states that if you don't file a tax return, if you don't need to file a tax return, the mandate doesn't apply to you.

Mr. ASTRUE. Mr. Griffith, if I could mention a parallel problem——

Mr. GRIFFITH. Sure.

Mr. ASTRUE [continuing]. I would hope that the committee would try to ask the GO to look at on a bipartisan basis. This country runs its defense these days a lot on young men and women who go in and out of the Reserves and National Guard into full-time deployment and then come back. The ACA does not fit very well people whose income goes up and down. The enrollment periods don't fit their employment. We need to be looking at some sort of grace period for people coming back from deployment. That is another group of young people I think are going to be very alienated from this system if we don't figure out a way to treat them better.

Mr. GRIFFITH. And I appreciate that, and obviously, we have heard about a lot of problems, not only today but other times, and you know, when you have constituents who were supposed to be helped by this program who find themselves not being helped and actually having equal or greater dilemmas than they had before, it just makes you realize, although I was not here at the time, that this wasn't a carefully-crafted piece of legislation, and as a result, we have a very flawed law.

I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentlelady from North Carolina, Ms. Ellmers, for 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman. I would like to ask every panelist here a very simple question. I just want to follow up on some of the comments and exchanges that have taken place.

One, do each one of you believe that in this country the American people should take care of those who cannot take care of themselves with coverage such as Medicaid?

And I will start with you, Mr. Astrue?

Mr. ASTRUE. [No audible response.]

Mr. ROY. Yes, but not with Medicaid.

Mrs. ELLMERS. But not with Medicaid.

Ms. CORLETTE. Yes, generally.

Ms. DIXON HILL. Generally yes.

Mr. STARK. Yes.

Mrs. ELLMERS. OK. I agree, too. I agree that we should take care of those who cannot help themselves.

Ms. Corlette, in an exchange with Mr. Green from Texas I believe Mr. Green asked you what the cost is today as healthcare coverage is, what the average individual pays to cover those who are uninsured. So healthcare coverage premium, I believe you said $1,000, but what, $1,000 a month, $1,000——

Ms. CORLETTE. Yes. I am really sorry, Congresswoman. I am not sure of the exact additional amount that those of us with coverage pay because of the uninsured. I just know we all pay more——

Mrs. ELLMERS. OK.

Ms. CORLETTE [continuing]. Because of uncompensated care.

Mrs. ELLMERS. OK. When you responded to Mr. Green and you said $1,000——

Ms. CORLETTE. That is the number I remember, but I——

Mrs. ELLMERS. One thousand dollars a year?

Ms. CORLETTE. I think so.

Mrs. ELLMERS. One thousand dollars a year. OK. The issue, and Mr. Roy, I do have some questions for you, but I do, Reverend Hill, I want to back up to you and just say how your situation, especially with the healthcare issues that you have faced, I can only imagine how devastating those were, especially with the Guillain-Barre. I have taken care of patients, and I know how devastating and how scared you must have been in many cases. So I just would like to say that.

So the $1,000 issue. So we will say a year or whatever. To that point, I think, to me that justifies exactly what we are talking about, which is I am hearing from—right now we have a number of 160,000 North Carolinians who are getting healthcare premium cancellations, and my understanding is it is from one insurer in North Carolina, and the comparable or what the Affordable Care Act would call for is comparable coverage or now increased coverage. Personally I say over-coverage or over-insuring is going up by thousands and thousands of dollars depending on the individual, depending on the plan that they have had with increased amounts in the thousands of their deductible.

So my question is if we are paying $1,000 more now with healthcare premiums and the ACA premiums are going up by thousands of dollars, are we fixing the problem, Mr. Roy?

Mr. ROY. Yes, and I would just start by saying if we look at national health expenditures, only about 1.7 percent of national health expenditures are uncompensated care in the emergency room. Of that 1.7 percent only about a third are relevant to the population that would be involved in rolling in the exchanges or the Medicaid Expansion. So it is actually a tiny fraction of health expenditures that are driven by uncompensated care in the emergency room, and yet as I noted in my opening remarks, in North Carolina the average person is going to see their individual market health insurance rates more than double.

And we saw this in Massachusetts with a much more highly-regulated market than North Carolina. So in Massachusetts uncompensated care was reduced by $200 million a year but increased spending on insurance subsidies was $800 million a year.

Mrs. ELLMERS. Uh-huh.

Mr. ROY. So there was a four to one ratio of savings from uncompensated care in the emergency room to increased spending.

Mrs. ELLMERS. So the numbers aren't adding up, essentially, and Mr. Astrue, you made a very important point earlier that you were having about choice and that really the American people should be able to have choice, and unfortunately, that is not what we are seeing, especially with the basic minimum standards or the essential health benefits that the mandate from the Affordable Care Act is putting forward. Is that not true?

Mr. ASTRUE. Yes. No. Thank you, and I would even be more specific and say the system right now tracks your location and wants to just give your information on that location, but this is a complicated country with complicated families. It is very typical, for instance, for one family member to be helping out another family member in another State——

Mrs. ELLMERS. Very true.

Mr. ASTRUE [continuing]. Or something like that. So I would say not only should you be able to shop in your own State, there is no reason in the world why you shouldn't be able to see in North Carolina or Texas or New Jersey if you are helping a parent or another family member what the policies are there because that is the way the country actually works in practice.

Mrs. ELLMERS. Well, and I will just couple that by saying that I do believe that our insurance industry and the way that we have pursued that in this country has needed reformed, and that is why I am supporting the RSC Plan of the American Healthcare Reform Act because I do believe it will provide choice and cover many of the solutions that we have seen that would work for affordable healthcare in this country.

So thank you all so much for your testimony today, and I truly appreciate it that, again, we are going to all have to come together and work on this to fix this problem, and I don't know how this is going to pan out. I don't know a timeline, but I do believe we can fix these issues, but it is going to need some significant work. So thank you.

Mr. PITTS. The gentlelady's time has expired.

That concludes the questions. I want to thank the witnesses for you excellent testimony, for answering all of our questions. Some members may have follow-up questions. We ask that you please respond promptly.

I remind members that they have 10 business days to submit questions for the record, and that will be by the close of business on Monday, December 2.

Excellent testimony. Thank you very much. Very important, very informative.

Without objection, the subcommittee is now adjourned.

[Whereupon, at 12:27 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115

Majority (202) 225–2927
Minority (202) 225–3641

December 3, 2013

The Honorable Michael Astrue
Former Commissioner of the
Social Security Administration
47 Benton Road
Belmont, MA 02478

Dear Mr. Astrue:

Thank you for appearing before the Subcommittee on Health on Thursday, November 14, 2013, to testify at the hearing entitled "Obamacare Implementation Problems: More than Just a Broken Website."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your response to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions and requests by the close of business on Tuesday, December 17, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

December 3, 2013

Mr. David R. Pitts
Chairman of the Subcommittee on Health
Committee on Energy and Commerce
Congress of the United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Pitts,

Thank you for your letter of December 3, 2013 asking me to respond to a question from Representative Bilirakis. The document I have attached to this letter is my response to his question.

Thank you again for providing me with an opportunity to share my views with your subcommittee.

Sincerely,

Michael J. Astrue
Interim Chief Executive Officer
InVivo Therapeutics Corporation

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

One Kendall Square
Building 1400 East, Floor 4
Cambridge, MA 02139

Attachment—Additional Questions for the Record

The Honorable Gus Bilirakis

1. **The IG's office issued a report back in August mentioning that implementation of security standards was behind schedule. According to the report, CMS' Chief Information Officer was expected to make his Security Authorization on September 30, one day before the Exchanges were to go online. Is it responsible to make this type of decision one day before launch? Would you ever have done that at the Social Security Administration?**

In my opinion it was irresponsible for HHS to plan for a security certification by its CIO one day before launch. Responsible operational and security testing of the beta version of a complex new system typically takes several months and cannot be done in a principled fashion in one day.

We never planned for a one-day test of a major new system at the Social Security Administration. To the best of my recollection we typically allotted about three months for operational and security testing, but my practice was always to delay launch if I believed a new system had serious operational or security flaws.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
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Majority (202) 225–2927
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December 3, 2013

Dr. Roger Stark
Health Care Policy Analyst
Washington Policy Center
P.O. Box 3643
Seattle, WA 98124

Dear Dr. Stark:

Thank you for appearing before the Subcommittee on Health on Thursday, November 14, 2013, to testify at the hearing entitled "Obamacare Implementation Problems: More than Just a Broken Website."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your response to that question in plain text.

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

WASHINGTON POLICY CENTER for health care

CONGRESSIONAL QUESTIONS November 14, 2013

The Honorable Gus Bilirakis

1. Under the ACA, half of the newly covered uninsured will gain their coverage through Medicaid expansion. This could be a 16 to 23 million increase in the Medicaid population. Does the ACA provide an increase in the number of physicians taking Medicaid? If there is no increase in physicians, would Medicaid patients end up back at the ER waiting for care? Isn't this one of the problems that the ACA was supposed to fix when it expanded Medicaid?

The ACA does not address the potential physician shortage in the Medicaid program. Our existing Medicaid patients frequently use the ER for routine care because of lack of timely access to primary care physicians. Expanding Medicaid to 16 to 23 million more Americans will only make this access problem worse. Unfortunately, the goal of the ACA has been to get more people covered with health insurance, without real concern for access to health care. Forcing millions of Americans into a substandard health insurance plan will in no way improve their overall health.

2. Under Medicaid expansion, the Federal government pays 100% of the cost for the first three years and then 90% of the cost after that, but only for the newly eligible under the expansion. For the legacy individuals, those who qualify under the old rules, the state still has to pay a large share of that cost under the old FMAP rules. Doesn't this create a perverse incentive for the states to target the newly eligible rather than legacy individuals?

Yes. However, because of the "welcome mat" or "woodwork effect" caused by the advertizing of the expanded Medicaid, states will be faced with hundreds of thousands of eligible people in the legacy Medicaid program. Officials in Washington state, for example, are encouraging eligible people to sign up under the existing Medicaid plan. This will place a huge burden on the Washington state budget because of our 42/58 (state/federal) FMAP.

3. There seems to be a desire to push Medicaid expansion and higher FMAPs as a solution to many problems in Medicaid. If States don't share as great a burden as they used to in Medicaid, then they could be less invested in stopping fraud. If the Federal government pays for more of the cost, doesn't it make the State less likely to police the Medicaid program because they have less skin in the game? Might waste, fraud and abuse increase in the program?

Definitely. Estimates of waste, fraud and abuse in the existing Medicaid program run as high as 30% of the overall cost – and this is with the states managing the program and its funding. With money coming straight from the federal government, states will have minimal incentive to monitor waste, fraud and abuse of Medicaid.

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